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ABSTRACT

An examination of the health status of blacks in each phase of the life cycle in New York State indicates a significant discrepancy between the health status of black and white New Yorkers, and a clear link between poverty and poor health. The following life stages were examined and key health issues were identified: (1) prenatal/newborn; (2) infancy; (3) childhood; (4) adolescence; (5) adulthood; and (6) old age. Detailed policy recommendations that emphasize community-based services, manpower needs, and education are suggested for each area. The following summary issues are discussed: (1) early prenatal care, nutrition, and immunization; (2) health and social services to prevent adolescent alienation; (3) preventive health care to combat the six most common causes of death among adults (cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide, and accidents); (4) social support services to combat Acquired Immune Deficiency Syndrome (AIDS); and (5) access to health care services for the elderly. Statistical data are included on 14 tables. Summaries of public hearings held in Buffalo and New York City are also included. Brief descriptions of the following programs are appended: (1) New York State teenage pregnancy and parenting programs, 1986; (2) violence prevention strategies; and (3) New York State Office of the Aging (SOFA) policies and programs aimed at elderly blacks. (FMW)

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**VOLUME 1**
**HEALTH**

ED348408

# BLACK HEALTH ISSUES IN NEW YORK STATE

# CONDITION
# PROGNOSIS
# PRESCRIPTION

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## REPORT OF THE HEALTH SUBCOMMITTEE

## THE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

**SEPTEMBER 1988**

---

**MARIO M. CUOMO**
**GOVERNOR**

**BERNARD L. CHARLES**
**CHAIRMAN**

**ROBERT T. SIMMELKJAER**
**EXECUTIVE DIRECTOR**

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GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

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NEW YORK, NY 10047

September 1988

Dear Governor Cuomo:

I am pleased to submit to you the Final Report of the Health Subcommittee of your Advisory Committee for Black Affairs, **BLACK HEALTH CARE ISSUES IN NEW YORK STATE: CONDITION, PROGNOSIS AND PRESCRIPTION.**

The Health Subcommittee of seventeen experts, under the leadership of Co-Chairpersons Judith Jones and Charles Felton examined the impact of a broad range of behavioral, societal and health-care issues as they impact on the more than two million Blacks in New York State, home of the nation's largest Black population. Using a multidimensional approach, the Subcommittee examined the health status of Blacks at every stage of the life cycle as well as the related issues of access and availability of medical care and health manpower. The findings presented show that while the health and longevity of Blacks in the Empire State have improved substantially, disturbing disparities continue to exist in comparison to other New Yorkers.

The pernicious link between poverty and poor health among Blacks is clearly established in our report. Some 26 percent of the Black families in New York State live below the poverty line. More than half of the Black population is concentrated in urban areas, where housing is substandard, schools overcrowded and environmental conditions hazardous. Their neighborhoods are plagued by crime, drug abuse, interpersonal violence and other detrimental lifestyles. Poor diets and malnutrition pervade, communicable diseases run rampant, health services are inadequate.

These harsh human circumstances would make anyone sick -- they are devastating for the increasing number of low-income Black New Yorkers.

The Health Subcommittee report reviews the several State programs and policies that serve well the critical health needs of Black New Yorkers and makes recommendations on the complex issues related to accessibility, availability and quality of health care services Statewide. Among the many strategies offered are the further affirmative actions the State must take to increase the number of health care professionals to directly serve the Black community.

The Subcommittee labored tirelessly to complete this report and I believe that they have made a significant contribution in setting forth an action agenda for Black health care concerns. The recommendations proposed by the Health Subcommittee, if implemented, will serve to place New York State in the forefront of what must be a national effort to ensure equality in health care for all New Yorkers, regardless of race or economic circumstances. I am confident that you will find the report useful in the formulation of State policies and programs that will further advance this important social objective.

Since submitting our preliminary report to you in July 1987, the Subcommittee has convened two well-attended public health hearings in Buffalo and in New York City. A summary of those hearings is included in this Final Report. The transcripts of each of those hearings has been submitted to you separately in order to distinguish the Subcommittee's deliberations from the Community's response.

Respectfully submitted,

Bernard L. Charles

Bernard L. Charles
Chairman

STATE OF NEW YORK
GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

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NEW YORK, NY 10047

September, 1988

Dear Chairman Charles:

We are pleased to submit to you the Final Report of the Subcommittee on Health of the Governor's Advisory Committee for Black Affairs. This Subcommittee of seventeen members, appointed by you in May 1986, met at approximately monthly intervals until December, 1987.

The issues identified during our deliberations and presented in this Final Report are of critical concern to the health and longevity of Black New Yorkers. The Subcommittee has examined the impact of a broad range of behavioral, societal and health-care issues and current State programs. The Report focuses on persistent disparities between the health status of Blacks and other New Yorkers. The particular influences of poverty and racism on health and care are recurrent themes.

The Subcommittee is offering an extensive series of policy and programmatic recommendations which, if implemented, we are confident, will improve the health status and health services delivery for Blacks in New York State.

This Final Report of the Subcommittee on Health includes a summary of the testimony on the Preliminary Report, which was widely circulated and reviewed at Statewide hearings held in September (Buffalo) and October (New York City). The hearings were intended to solicit community response and participation in our process. The transcript of each of those hearings has been submitted to you separately in order to distinguish the Subcommittee's deliberations from the community's reponse.

It has been a priviledge to be associated with such a hardworking and dedicated group, whose members gave so generously of their time and expertise. The Subcommittee joins us in acknowledging our great appreciation for the contributions and support of the research staff, Ruth C. Browne and Charleen Ward. We are particularly appreciative of the quality of work provided by Robert Osborne and Patricia Morisey who served as consultants.

On behalf of the Subcommittee we wish to express our appreciation for the opportunity to examine these health and health-related issues.

Sincerely,

Charles Felton, Co-Chair
Subcommittee on Health

Judith Jones, Co-Chair
Subcommittee on Health

## ACKNOWLEDGEMENTS

The Subcommittee wishes to acknowledge with gratitude the contributions of many individuals whose information and knowledge of the issues assisted in the formulation of this report. Particular appreciation is expressed to:

**ELAINE BLYDEN**
Office of Honorable Arthur Eve
New York State Assembly

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Mental Retardation and Alcoholism Services

**DOROTHY COLLIER**
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**CLIFTON HATCHENSON**
Geneva B. Scruggs Health Center

**RENELDA HIGGINS**
North General Hospital

**LOUISE HOPKINS**
Kenfield - Langfield
Youth in Progress

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**MAGGIE WRIGHT**
State University of New York, Buffalo

2. The Committee shall create a panel, whose members shall be designated subject to the approval of the Governor, to address the unique concerns of the Black family, with particular emphasis on households headed by Black women. The Commissioners of Human Rights, the Director of the Women's Division and the Executive Director of the Council on Children and Families or their designees shall provide assistance and advice to the panel.

3. The Committee shall establish subcommittees, which shall make recommendations concerning the special needs of various Black cultural and ethnic populations, including the Caribbean community. Such subcommittees shall periodically submit reports to the Committee for its consideration and adoption.

4. The Committee, in conjunction with the Governor's Executive Committee for Affirmative Action, shall review the implementation of affirmative action programs designed to increase employment opportunities for Blacks in State government.

5. The Committee shall report on a regular basis to the Governor on its activities.

6. The Committee may request and shall receive from any department, division, board, bureau, commission or agency of the State such assistance and data as will enable it to carry out its purpose and responsibilities hereunder.

GIVEN under my hand and the Privy
Seal of the State in the City of
L/S Albany this fifth day of
June in the year one thousand
nine hundred eighty-five

BY THE GOVERNOR /s/ Mario M. Cuomo

/s/ Michael J. Del Giudice
Secretary to the Governor

State of New York

Executive Chamber

No. 66

# EXECUTIVE ORDER

## ESTABLISHING A GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

**WHEREAS**, members of the Black community have contributed significantly to the State and its government to the benefit of all of the people in the State; and

**WHEREAS**, the State must continue to be responsive to the special needs and concerns of its Black residents; and

**WHEREAS**, a mechanism must be established to ensure that members of the Black community have opportunities to participate in all levels of government;

**NOW, THEREFORE**, I, Mario M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and the Laws of the State of New York, do hereby order as follows:

### I. Governor's Advisory Committee for Black Affairs

There is hereby created a committee to be known as the Governor's Advisory Committee for Black Affairs (the "Committee"). The members of the Committee shall be appointed by the Governor. A chairperson and vice chairperson shall be designated by the Governor. The members of the Committee shall receive no compensation, but shall be entitled to reimbursement for any necessary expenses incurred in connection with the performance of their duties. The Governor shall designate an executive director of the Committee who shall be responsible for its administrative functions.

### II. Purpose and Responsibilities of the Committee

1. The Committee shall identify and evaluate areas of particular concern to the Black community and submit recommendations to the Governor for his review. The Committee shall place special emphasis on the following areas:

    a. development of increased opportunities for involvement of Blacks in all aspects of State government.

    b. coordination of resources to create effective educational, vocational and health training programs.

    c. evaluation of policy decisions affecting the Black community.

    d. evaluation of programs and services provided by State agencies and their impact on the Black community.

    e. development of awareness programs to assist members of the Black community in identifying and participating in programs sponsored by the State and local governments.

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NEW YORK STATE OFFICE OF THE AGING

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Dr. Christmas is a psychiatrist in private practice in New York. She is also a Medical Professor and Director of the Program in Behavioral Science at the Sophie Davis School of Biomedical Education of the City College, City University of New York. In addition, she is an Adjunct Professor at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. Dr. Christmas served for eight years as Commissioner of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. She served as Executive Coordinator of the Panel on Community Support Systems of President Carter's Commission on Mental Health. Dr. Christmas has published extensively on public health and minority health issues, community mental health, alcoholism services, rehabilitation and social policy. She received her M.D. from Boston University.

## GERALD W. DEAS

Dr. Deas is an attending physician at Jamaica Hospital and an Associate Professor in the Department of Preventive Medicine at SUNY Health Science Center at Brooklyn. He is a specialist in ambulatory care and practices at Carter Community Health Center in Queens. Dr. Deas is the founder of the Sickle Cell Victims Organization, Inc. He is a health commentator on several television (The McCreary Report, WNEW Channel 5 TV) and radio (WBLS, WLIB, WWRL, WABC) programs and has written extensively on iron deficiency anemia, laundry starch ingestion, abortion, smoking, alcoholism, sickle cell anemia and a wide range of health-related issues. An expert in the area of preventive medicine, Dr. Deas received his M.D. from Downstate Medical College.

## CHARLES P. FELTON

Dr. Felton is the Acting Director of Medicine for the Harlem Hospital Center. He is also a Clinical Professor of Medicine in the College of Physicians and Surgeons at Columbia University. The Secretary-Elect and member of the Board of Directors of the American Lung Association, he also serves on the Medical Advisory Committee of the Greater Harlem Nursing Home. Dr. Felton is an internal medicine and pulmonary specialist and has published extensively in the area of tuberculosis research. He received his M.D. from the University of Geneva.

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Carole Morris has served for ten years as Executive Director of the Mount Vernon Neighborhood Health Center. She is the immediate Past President of the Community Health Care Association of New York State and serves on the Legislative and Medical Malpractice Committees of the National Association of Community Health Centers. Ms. Morris received her B.S. from Columbia University.

## LEITH MULLINGS

Leith Mullings is an Associate Professor at the City University of New York Medical School and Department of Anthropology of the City College. In addition, she serves as Director for the Medical Anthropology Program. Dr. Mullings has taught anthropology, cross-cultural issues and urban studies at numerous universities, including the University of Dar-es-Salaam, Yale and Columbia. Extensively published, she is the author of Therapy, Ideology and Social Change: Mental Healing in Urban Ghana and editor of The Anthropology of Urban America. Dr. Mullings serves as President of the Metropolitan Medical Anthropology Association. She received her Ph.D. in anthropology from the University of Chicago.

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## MURIEL PETIONI

Dr. Petioni, a practicing physician in the Harlem community, is a general practioner and Clinical Professor of Pediatrics at Harlem Hospital Center. Dr. Petioni is Founder and First Chairperson of the Susan Smith McKinney Steward Medical Society. She is a member of a number of civic and professional organizations and advocacy groups, including Delta Sigma Theta Sorority, the Coalition of 100 Black Women and New York City Department of Health Child Health Forum. Dr. Petioni received her M.D. from Howard University.

## BENY J. PRIMM

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## EXECUTIVE SUMMARY

# BLACK HEALTH CARE ISSUES IN NEW YORK STATE: CONDITION, PROGNOSIS, PRESCRIPTION

The Health Subcommittee of the Governor's Advisory Committee for Black Affairs consists of professionals based in New York City, its surrounding areas, and upstate New York. The Subcommittee examined the health status of Blacks in each phase of the life cycle from the maternal age group, through infancy, childhood, adulthood and the elderly years.

Black Health Care Issues in New York State: Condition, Prognosis, Prescription, the preliminary report of the Health Subcommittee, reveals that the health status of Blacks has improved nationally. There are however, disturbing disparities in health status that exist between Blacks and other New Yorkers, and there is a clear link between poverty and poor health. An analysis of New York's economic, social and health indicators supports the conclusion that Blacks of all ages are grossly over-represented among the poor.

Poverty recognizes no age boundaries. In 1985, the poverty rate among Black children, aged eighteen and younger, in New York, was 41 percent. This is considerably higher than in 1980 when it was 36 percent. There is more poverty among inner-city Black children than children Statewide. Poverty is characterized by overcrowded housing and hazardous fires, traffic, pollution and other adverse environmental conditions. Moreover, many predominantly Black neighborhoods are plagued by drug abuse, crime, interpersonal violence, and many other detrimental influences. Conclusively, the existing data links health status to socioeconomic conditions. In addition, poor educational attainment and inadequate income are major factors in disease and death among Blacks.

The Subcommittee's assessment was organized in a manner in which specific stages of life were examined. Recommendations specific to the health needs found in each stage of the life cycle are proposed. The Report offers an analysis of a number of overarching factors that impact on the health status of Blacks in New York and that determine whether Blacks will have access to timely, quality and equitable care. Examined are the related issues of availability of preventive care in communities, quality of care, utilization of services, and health care financing. Particularly emphasis is placed on health manpower and the need to increase the numbers of Black health and medical professionals as well as the number of Black faculty and students in health training institutions.

The Report identifies a number of maternal child health issues which have particular relevance for the development of Black children. These include early and continual prenatal care for women, supplemental feeding programs to improve nutritional status, family planning and interconceptional care, child health services--with a focus on school-based clinics--and the importance of immunization.

The Report examines the special problems faced by Black teenagers in their transition to adulthood, specifically the lack of economic opportunity, poor schooling, racism and poverty. These all contribute to the alienation of Black youth and are reflected in symptoms like dropping out of school, teen pregnancy and too early parenthood, substance abuse, and homicide. Therefore, proposed recommendations emphasize early problem identification and comprehensive preventive-oriented services in Black communities. These services provide both the health and social supports that so many Black youth are without.

The Report provides a strong rational for increased and better services in the Black community by focusing on those health problems which act as obstacles to productivity in Black adults. Particular attention is focused on the six causes of death among Blacks that account for thirty percent of Black mortality (cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide, accidents and infant mortality) and to the need for a preventive mental health service strategy which builds on the strengths of the Black community and its institutions.

The Report clearly identifies AIDS as the most devastating disease to impact the Black community, primarily because of a disproportionate number of IV drug users. In this regard, serious unmet needs exist for social support services in predominantly Black communities. A report issued by the Human Services Subcommittee entitled AIDS in the Black Community, which was made available prior to the hearing, accordingly focuses on community-based social services including drug treatment, health care, culturally appropriate education, the development of Black professionals in AIDS research and service provision, foster care case management and housing.

Finally, the Health Report concludes with an analysis of the special problems confronted by the Black elderly, who face not only deteriorating health but poverty as well. For the Black aged who live shorter lives and die more frequently from chronic diseases, access issues are, again, especially significant. Specific needs include access to nursing home care, home-based and community-based services.

Thus, it is clear that the disparity in health status between Blacks and other New Yorkers is largely due to poverty, the impact of poverty of time and the ability to exercise personal lifestyles that are important in improving health status. Black communities are at risk because of their inability to control many of these influential factors. There is a critical need to place emphasis on the early stages of life in order to prevent the chronic dependencies and disabilities that the Report clearly identifies as common among Blacks in the elderly years.

## RECOMMENDATIONS

The Health Subcommittee has developed the following initiative to coordinate health needs of Black New Yorkers.

- The State should establish a permanent Office of Black Affairs with a Division on Black Health to address the health and health-related needs of Blacks. The Black Health Division would support existing facilities and programs and initiate the development of new programs by local organizations and corporations. The Division would have a policymaking, coordinating and monitoring function with direct links to the Executive Office.

### Community - Based Services

The Subcommittee identified problems in each phase of the life cycle and developed corresponding health service recommendations. These recommendations address the need for quality, accessible community-based comprehensive health services, with an emphasis on preventive care.

There are significant gaps in access to services and in the availability of health care in poor Black communities. For example, there are less than 50 community health centers operating in New York State, treating only 500,000 of 2.2 million Medicaid-eligible persons. About 40 percent of the poor, 4000,000 persons, including 100,000 children are left uncovered. An additional 340,000 persons with incomes just above the poverty level fall into this same gap in health coverage.

- The State should support community-based comprehensive health centers and the effort to make preventive health care accessible to the medically indigent in the Black community. In addition, hospitals and community-based clinics that serve predominantly Black populations should be supported in developing, providing and expanding a full range of comprehensive health services.

- The State should support two key Department of Health initiatives: (1) management assistance and and (2) the development of additional sources of capital for expansion of community-based comprehensive health centers.

The diffusion of information aimed at ethnic and culturally diverse populations is more likely to be successful if it is planned at the community level. A partnership must be developed between local communities and government.

- The State should develop innovative approaches to motivate Black families to seek preventive care, i.e., use of home visitors. Soliciting the technical assistance of Black community-based organizations in this regard is imperative.

- The State should ensure that health information is disseminated in the Black community and should improve and expand its outreach programs.

The Governor's Medicaid Reform strategy for developing a systems approach to foster preventive medicine and develop community health clinics discourages episodic and fragmented care. The following recommendations would better serve the Black community.

- Expand Medicaid eligibility to 100 percent of the poverty level for families of all sizes. The program could then draw into an insured pool thousands of poor New Yorkers who presently have no health insurance coverage.

- Extend medical insurance, through Medicaid or some other form of social insurance, to the working poor.

- Increase Medicaid reimbursement fees to retain and to encourage the participation of private physicians and specialists in the program.

- Decrease Medicaid recipient reliance on hospital emergency room, outpatient department care and shared health facilities by developing opportunities for preventive care and private physicians services or other forms of prepaid enrollment plans. This measure would be instrumental in helping to achieve the objective of case-managed, preventive care.

Lack of information and inadequate preventive treatment programs are major contributors to the disparties in health status between Blacks and non-Hispanic whites.

- The State should initiate public health and information campaigns focused on -- smoking, diet, cancer warning signs, prenatal care and regular checkups -- as important preventive activities related to specific diseases.

- The State should target diseases that disproportionately affect ethnic groups, allocating funding for prevention and treatment.

## Health Manpower & Education

Minority access to health careers has not improved over the last decade. New York State has lagged behind the national average in the number of minorities enrolled in most health professional training programs.

- The State should implement those recommendations proposed by State Task Forces that would facilitate increasing the number of Black physicians and specialists practicing in the State, including those proposals; to strengthen the early academic preparation of Black students; to disseminate information on health career opportunities to Black students; to review medical school applicants; and to expand medical school recruitment, financial aid and retention of Black students.

- The State should implement an aggressive plan to increase scholarships and to waive the income eligibility requirements for low-interest health career education loans for underrepresented Blacks. Concurrent efforts should be put forth for the training and development of Black faculty in the the health fields, especially at State-supported institutions.

Federally sponsored programs and incentives from 1964 to 1974 expanded opportunities in health care for Blacks. From 1969 to 1981-82 Black enrollment in medical schools increased from 1,042 (2.8%) as a percentage of total enrollment to 3,884 (5.9%). The number of Black practicing physicians nationwide only rose 0.5 percent from 1950 (2.1% or 4,026 physicians) to 1980 (2.6% or 4,026 physicians) to 1980 (2.6% or 11,700 physicians). In 1978 the ratio of physicians to population within the boundaries of East and Central Harlem was less than one physician per 7,000 residents and one per 6,000 residents, respectfully. By 1980, the ratio in these two areas worsened, falling to one physician per 15,000 residents.

> Institutions that have traditionally been responsive to the needs of the Black community, such as City University of New York and the Sophie Davis School of Biomedical Education, should be supported with substantial resources to enable them to continue and expand programs. These training institutions provide the opportunity for early academic training for Blacks interested in the health professions.

New ways of organizing and financing health care, the changing role of hospitals as the major providers of ambulatory care and the keen completion with the private sector for secondary and tertiary services have jeopardized the very existence of institutions, such as Harlem Hospital, with a history of serving predominantly Black communities.

- Funds should be appropriated for the support of institutions such as Harlem Hospital, to train physicians, nurses and other allied health professionals, thereby facilitating smoother entrance for Blacks into health careers.

The Commission on Graduate Medical Education has proposed incentives for New York medical schools to accept more minority students. These medical schools should implement an affirmative action policy to increase the pool of applicants, to raise the rate of acceptance and to retain students who enroll in medical school programs.

- A State Council on Career Opportunities in the Health Professions should be established to provide a focus for State efforts to increase the number and proportion of Blacks in medicine, nursing and allied health services.
- The State should strengthen recruitment and retention programs for Blacks in existing health programs at the college, professional, high school and junior high school levels. To encourage retention, funding should also be allocated for peer-support groups.

There is gross underrepresentation of Blacks in medical and dental schools in New York State. All of the professional health training programs in the State University of New York (SUNY) systems show minority enrollment of less than 10 percent. Indeed, most programs show enrollments below five percent. The thrust toward decreasing enrollments in these programs clearly should not include underrepresented minorities.

- The State should review the present thrust to curtail the use of qualified Blacks trained at foreign medical schools.
- The State should establish an office whose primary responsibility would be to collect, analyze and disseminate information on the representation of Blacks in the health fields. The Office would be a permanent part of the State Department of Health.

Given the substantial public financing which supports the University, SUNY's minority enrollment in the health professions programs is unacceptable.

- State financial support for educational institutions should be linked with the performance of these institutions in the enrollment and retention of Black students. The State must also develop career paths for Blacks in the health professions.

## Maternal Health

A concerted State effort is required to ensure that Black women in particular obtain the care needed for their own physical well-being and that of their infants and children. In the area of maternal health the Subcommittee places primary emphasis on the promotion of early and consistent use of prenatal care by pregnant women.

- The State should ensure universal access to prenatal care services and support and initiate the development of appropriate, accessible, culturally compatible services. In addition, the State should develop on-going means of monitoring the efficacy of the regional perinatal networks.

In 1983 New York State ranked 46 out of 51 states for Black women receiving early care and 47 out of a rankable 48 States for non-white women receiving late or no prenatal care. The State's Black infant mortality rate in 1984 was nearly twice that of whites; neonatal mortality for Blacks was nearly two-thirds higher. The relationship between early prenatal care and normal birthweight has been established.

o The State should implement a comprehensive strategy to develop non-traditional approaches targeted to Black mothers, to encourage them to seek early prenatal care. This program should include a strong parent and nutrition education component of the WIC Program, and should encourage Black women to consider breastfeeding.

o The Subcommittee fully supports the recommendation of the Department of Health and and Human Services, "1990 Objectives for the Nation" report to develop, implement, and evaluate health education (through work sites, schools, mass media, etc.) on the avoidable risks to maternal and fetal health during pregnancy, i.e., poor nutrition, use of alcohol, cigarettes and drugs, and the importance of breastfeeding.

## Infant Health

In the area of infant health, concerns include "boarder babies" (any infant who stays in a hospital beyond the time that they require medical care) and AIDS babies.

o The State should provide adequate supports which would increase the willingness and ability of Black families to provide foster care. In addition, the State should make available preventive mental health services to avert retardation.

o Address the needs of infants at medical and/or social risk for physical and/or developmental problems (i.e., infants with AIDS or genetic problems, etc.) by increasing the funding available for the Infant Health Assessment Program (IHAP) which currently meets only 60% of need.

o Ensure universal access for infant health care services, including expanding access to the WIC program and immunization services. This will also require non-traditional approaches to outreach.

## Child Health

In the area of child health, the Subcommittee identified immunization, day care sanitation, nutrition and dental care as priority issues.

- The State should ensure immunization of toddlers in and out of day care programs for Hib, MMR, polio and DPT. The State should also ensure increased availability of free vaccines to primary health care providers in high-risk areas:
- The State should expand the current State-funded school demonstration projects into permanent programs in elementary schools, where low cost or no cost primary health services are not readily available. These programs should be institutionalized so that they are available in all high-need communities across the State. This may require changes in both health and education statutes and will require additional State funding.
- The State should ensure improved sanitation standards (good hygiene practices) in day care programs. Small group settings should be encouraged.
- The State should provide adequate health education for day care and WIC program staff and families on nutritional and genetic issues, particularly obesity, iron deficiency and sickle cell anemia. The State should expand its nutrition education efforts and food supplementation as needed, particularly to address obesity and iron deficiency in Black children.
- The State should increase access to dental health services for Black children who do not receive regular dental care.

## Adolescent Health

In the area of adolescent health the Subcommittee identified the increasing rates of homicide and suicide, teen pregnancy and substance abuse among Black youth as priorities. Therefore, an overall focus on comprehensive health care, including school health programs and preventive day treatment programs is recommended.

In order to meet the challenge created by this growing crisis among Black adolescents, as well as young adults aged 18 to 24 years (the latter group being in particular need of services because of their "aging out" status in the traditional mental health delivery system), creative approaches to service delivery for this population are required.

- The State should develop comprehensive multi-funded adolescent health and mental health service programs (e.g., The Door in Manhattan) in New York City (specifically Harlem and Bedford Stuyvesant), Westchester and Buffalo, focusing on early identification and prevention. The program would include prenatal care, health and social services, crisis counseling and education.

- In New York City the Council's Center for Problems of Living has developed a proposal for a comprehensive regional program model for Black youth, which would include targeted services in the lower Bronx, Inwood, West Harlem, Washington Heights and Central Harlem. This proposal should be state-supported and replicated in other areas of the state.

- The State should develop a demonstration program of "presumptive eligibility." Such a program would presume all adolescents in specific geographic areas eligible for at least a first primary care visit. Presumptive eligibility would eliminate means tests and determine eligibility based on residence in areas with low socio-economic indicators.

- The State should provide alternatives to traditional mental health services to Black adolescents and young adults, for whom such services might otherwise be unavailable or inaccessible (i.e., truants, high school dropouts, homeless and/or shelter-based youth, etc.).

- A variety of coordinated interventions and comprehensive programs should be available and accessible to needy Black youth statewide and should include but not be limited to walk-in and crisis psychiatric services, b) parenting groups for teenage mothers and fathers, c) family support services, d) short-term counseling, e) alcohol/substance abuse counseling, f) educational/vocational and general life skill development services, and g) interpersonal violence prevention programs.

- The State should develop program models for Black adolescents and young adults who, while not suffering from a clearly defined diagnosable "mental illness," nonetheless are deficient in basic social, education, vocational and general life skills.

## Adult Health

The health problems which affect the Black adult population with greatest prevalence are conditions which, to a large extents are either preventable or amenable to effective early detection and/or intervention. The increasing incidence of AIDS, cancer, hypertension, stroke, diabetes mellitus, chemical dependence and its complications are foremost in this population, and are responsible for morbidity which can be significantly reduced.

- The State should develop statewide comprehensive community-based programs targeted at the aforementioned problems via screening, data collection and prevention.

- The State should provide improved access to health services by improving and expanding services and/or facilities in under-served areas. Priority for expansion should be given to existing providers with a history and track record for service provision in the Black community.

- The State should modify existing Medicaid eligibility to expand the numbers of poor who would qualify.

- The State must develop a partnership between local communities and government to assist ethnic communities develop their own culturally relevant methods of solving health problems.

- The State should mandate the development of an accurate health status data base on all ethnic populations in New York. The terms minority, non-white, other have become irrelevant in the collection and interpretation of vital health statistics. Among Black New Yorkers, specific data on native born Blacks, Caribbean Blacks and Africans are more appropriate categories for health information reporting purposes.

- The State must improve access to health statistics so that health professionals at all levels can use such information in their planning efforts.

- The Department of Health should develop the capacity to analyze data regarding the provision and effectiveness of services in the Black community.

- The State should also increase the funds available to already existing drug and alcohol treatment programs and Black social service agencies with a history and successful track record in service to the Black community.

- The State should establish crisis counseling centers and develop a range of day-treatment programs in the Black community to provide early identification, ongoing support and preventive mental health.

- The State should direct major health funding into the Black community for community-based services, specifically residential rehabilitative care and case-management services for the chronically mental ill.

- As recommended by the Minority Advisory Committee of the State office of Mental Health, the State should establish an Institute for Mental Health Research and

Policy on Racial Minorities. The State Office of Mental Health should be required to collect and analyze data by race and ethnicity.

- The State should identify Black mental health professionals for appointment to middle management, research and administrative positions, to facilitate the development and implementation of culturally relevant mental health services.

- The State should initiate research on the design of mental health treatment programs that will address issues of particular concern to Blacks and encourage the use of Black researchers in State mental health consultant contracts.

- The State should increase the availability and accessibility of preventive mental health services for high risk populations.

- The State should subsidize the training of medical and allied health professionals who will serve Black communities and establish satellite clinics with simple registration procedures and hours convenient to the working adult.

In the area of elderly health the Subcommittee identified the following priority issues: (1) organized legislative and individual advocacy on behalf of Black elderly, (2) expanded training for elderly care providers, home attendants and home health care providers and (3) specialized housing for independent living.

- The State should offer broad-based training, retraining and specialized training for home care workers; improve salaries for care providers and enforce standards to assure quality care.

- The State should develop public service announcements (PSAs) targeted at the Black elderly and focused on available services. Collaborative efforts with public and private organizations, including Black churches, social and fraternal organizations, should be initiated and a public education/information campaign targeted at the Black community should be conducted through this effort.

- The State should improve the quality of home care services and extend skilled nursing care to those elderly persons requiring acute care. The availability of acute care, access to nursing home beds and day care facilities in communities with predominantly Black populations of elderly should be increased.

- The State should ensure that short-term and long-term home health care services are available for the elderly. Physicians or mid-level practitioners should be scheduled to make periodic home visits, particularly to those elderly residing in predominantly Black communities. There is an even more critical need for nonmedical home care to be made available and accessible in Black communities.

- The State should develop a program to place mid-level and allied health practitioners, trained in geriatric care, at senior centers located in predominantly Black communities.

- The State should ensure increased access to and availability of services to the Black elderly with particular emphasis on acute care, nursing home care, chronic care, home care services and preventive services.

# INTRODUCTION

The Health Subcommittee of leading health-care professionals developed a broad multidimensional approach to the review of the health problems of the more than 2 million Blacks in New York State, the home of the nation's largest Black population.

The health status of Blacks was examined in each phase of the life cycle--maternal, infant, childhood, adolescence, adulthood and the senior years. The related issues of service, access and availability of medical care and affirmative actions to increase the number of medical and health-care professionals to serve the Black community were also carefully considered by the Subcommittee.

A review of the data revealed that in New York State, as in the rest of the nation, the health status of Blacks has improved substantially, however, significant disparities continue to exist between Blacks and other New Yorkers.

The preliminary findings of the Subcommittee clearly establish the pernicious link between poverty and poor health. A complex interaction of socio-economic and behavioral factors have been found to adversely affect the health and longevity of Black New Yorkers.

An analysis of economic, social and health indicators supports the conclusion that Blacks -- of all ages -- are grossly overrepresented among the poor. More than one in four Black New Yorkers is poor compared to less than one in thirteen white New Yorkers.

This pervasive poverty recognizes no age boundaries. In 1985, the poverty rate among Black children aged eighteen and younger in New York State was 41 percent, considerably higher than in 1980 (36.8 percent). Black children living in inner cities had higher rates of poverty than children Statewide. For example, one of every two Black children under sixteen years old in Buffalo was living in poverty. Nearly half of the Black elderly in New York State (49.5 percent) live at or below the poverty level: 29 percent below poverty and 20.5 percent in marginal poverty.

New York State has a much higher proportion of its poverty population concentrated in poverty areas than the nation as a whole. More than half of the State's 2.4 million Black New Yorkers are concentrated in New York City (1,784,337); the counties of Westchester, Erie, Nassau, Suffolk, Monroe and Onondaga; and the major upstate urban cities of Buffalo, Rochester, Syracuse, Albany, Schenectady and Troy.

The Black poor are massed in urban areas which have substandard, overcrowded housing and hazardous fire, traffic, pollution and other adverse environmental conditions. Their neighborhoods are plagued by drug abuse, crime, interpersonal violence and a myriad of other detrimental lifestyles.

These encumbered Black communities have reduced access to preventive health services as well as to acute and long-term care. Low birthweight, infant mortality, chemical dependence and incidence of cancer and cardiovascular disease have a disproportionate impact on Black New Yorkers. While causal relationships cannot be established, the data link health status to living conditions.

The Health Subcommittee was influenced by the findings of the Federal Task Force on Black and Minority Health, which affirmed that "lack of education and income are major factors for disease and death in Blacks." The review and analysis of data by each of the working groups of the Health Subcommittee fully supports this view.

Chapter 1, Equity in Black Health Care in New York State, provides the context for looking at the health status of Blacks in New York. The evidence underscores the insidious relationship between lower socio-economic status and poor health. There are a significant and growing number of Blacks concentrated in central city poverty areas. This concentration is more severe in New York City where 86 percent of Blacks live in neighborhoods where 20 percent or more are poor, and 45 percent live in areas where 40 percent are poor. A review of the literature on Black health suggests that four social characteristics are especially significant to health status:

1) demographic profiles
2) nutritional status and dietary practices
3) environmental and occupational exposures
4) stress and coping patterns

This chapter reviews the data on the six causes of mortality which together account for four of every five excess deaths of non-whites aged 70 and younger:

- cancer
- cardiovascular disease and stroke
- chemical dependency
- diabetes
- homicides and accidents
- infant mortality

The data were taken from national surveys and, with few exceptions, the evidence suggests that the health of Blacks in New York does not differ significantly.

An analysis of access, availability and quality of services is also provided. It points out that, in part, the health status differencas observed between Blacks and whites can be attributed to several indices of health care resources: health services utilization, health financing, availability of health-care facilities and providers, health knowledge and behavior. Implementation of the Diagnostic Related Groups (DRGs) in the Medicare program is reviewed. DRGs are mechanism for reimbursement which may negatively affect the poor Blacks and particularly the Black elderly. A discussion follows on community health centers a source of accessible medical care in poor neighborhoods; Medicaid, which was designed to increase access to care for the poor; and the School Health Demonstration Program, which brings health services to children in schools.

The dire need for human resources development to increase the number of health and medical professionals in Black communities is addressed. The Subcommittee takes the position that priority should be given to a comprehensive strategy to include tutorial programs, effective financial and academic support systems, recruitment and development of Black faculty members and an institutional commitment to recruit and retain Black students in the health professions.

Chapter 2, The Development of Black Children in New York: Selected Issues in Maternal, Infant and Child Health, emphatically states that at no other point in life are interventions which emphasize the needs of at-risk children more potentially successful than in infancy and early childhood. The critical issue of access to maternal health care, particularly prenatal care, is reviewed as well as the barriers to care, including financial access, limited availability and quality of services, and lack of targeted education and outreach.

Strong evidence to support the impression that substance abuse has become a serious problem among pregnant Black women is presented. The Women, Infants, Children (WIC) program to improve birth outcome and infant survival and the positive impact of family planning services on the infant mortality rate in New York is supported.

The Black infant mortality rate is nearly twice that for white infants. The complex set of interrelated factors which stunt the survival of infants -- birthweight, nutrition, physical and developmental problems, AIDS, access to prenatal care and health services -- are closely examined in this chapter. The chapter provides evidence that supports the assertion that while infant mortality has declined in the last decade, the racial differential can be further reduced by improving the survival of Black infants that are born healthy.

Detailed are the special problems which affect Black children -- nutrition, immunization, dental care, access to child health services, sickle cell anemia and lead poisoning. The critical correlation of poor nutrition, exacerbated by poverty, in many Black families is identified.

Chapter 3, Risk-Taking and Resilience: Troubled Youth In Transition. The Health Implications for Adolescents, considers the importance of examining the social context of Black adolescent development. Statistics show the alarming degree to which Black youth lack both the skills and opportunities to become self-sufficient adults. Economic and social pressures encountered by Black youth contribute to apathy, indifference and hopelessness. This alienation of New York's Black youth is manifest in premature childbearing, dropping out of school, juvenile delinquency, homicide, drug abuse and other serious social problems.

There is an extensive discussion of the physiological, social and economic conditions associated with Black teenage childbearing and the adverse consequences for adolescent mothers and their children. Data are presented which show that major poverty areas have the highest proportion of teen births and posits that early childbearing is associated with longer duration on public assistance.

Underscored is the especially stressful experience of Black adolescents, whose coming of age is complicated by racism and poverty. The homicide rate for Black males age 10-19 in 1984 was thirteen times higher than that of their white counterparts. The factors, including racism, which contribute to the overrepresentation of Black youth in interpersonal violence are delineated.

In Chapter 4, The Productive Years of Life: Select Causes of Morbidity and Mortality Among Black Adults in New York State, the impact of social and economic stresses that interfere with health and longevity is reiterated. The review and analysis of the data support the findings of the Federal Task Force on Black and Minority Health which identified six critical areas that account for more than 80 percent of Black mortality and reflect the health disparities between Blacks and whites:

- cancer
- cardiovascular disease and stroke
- diabetes
- homicide
- suicide and accidents
- substance abuse

AIDS, rapidly becoming the most devastating disease to impact upon the Black community, is spreading primarily owing to intravenous drug use. Intravenous (IV) drug users are identified as the fastest growing percentage of the population with AIDS.

The incidence of tuberculosis (TB) among Blacks has increased since 1978, greatly exceeding the average rates in the State, and in this chapter the relationship between TB and to substance abuse as well as environmental factors are examined.

The discussion of the mental health status of Blacks in New York is closely examined. Poverty is pointed out as a major cause of stress, particularly when linked with the pressures of single parenthood, low educational attainment, unemployment and a hostile urban environment. Support for preventive mental health strategies, which build on the strengths of the Black community and its institutions, is imperative.

In Chapter 5, Health Services for the Black Elderly: The Challenge Facing New York State, we find that Black people in their elderly years continue to confront the same problems of their adult lives -- poverty and resultant poor living conditions. The Black aged are in poorer health than their white counterparts, living shorter lives and dying more frequently from chronic diseases. In 1983 the life expectancy for Black males was 65 years as compared to 72 for white males. Similarly, the life expectancy for Black females was 74 years as compared to 79 years for white females. Poverty, poor diets and excessive drinking and smoking contribute significantly to morbidity and mortality among the Black aged.

The full extent to which the current health care system fails to meet the needs of the Black elderly is presented in detail. The Medicare DRGs reimbursement system for hospitals raises the serious concerns regarding access and premature discharge. There is clear evidence of discrimination in nursing home care.

The Subcommittee placed particular emphasis on the need for community-based supportive and home care services for the elderly in Black communities.

## CHAPTER 1

## EQUITY IN BLACK HEALTH CARE

As the general health of the nation improves, gaps between the health status of Blacks and whites continue to signal disturbing disparities in the availability and access to quality health care. Advances in health science technology, knowledge and management of diseases and developments in medication and treatment have led to marked improvements in the health and longevity of Americans. Yet, while the fourteen-year life span gap between Blacks and whites at the turn of the century has narrowed, white Americans can expect to live five-and-one half years longer than Black Americans. And while important gaps among other indicators have closed somewhat over the last few decades, Blacks are still far less likely to receive the type and quality of care or to experience as positive health outcomes as whites.

New York State, home to the nation's largest Black population, has shared in the positive outcomes of technological and medical breakthroughs. Yet, like the nation as a whole, important disparities in health status remain between white and Black New Yorkers. This report provides the context for taking a closer look at the health status of Blacks in New York. It highlights several issues related to access and availability of medical care and to providers of that care, and argues a social and economic urgency for moving equity to the top of the health agenda.

## The Context

### Population

In 1980, New York's population was 17,558,072. Blacks comprised almost 14 percent of this population (2.4 million people), primarily concentrated in New York City (1,784,337) and the counties of Westchester (104,815), Erie (102,947), Nassau (90,743), Suffolk (71,741), Monroe (71,041), and Onondaga (30,117). The major urban cities in which Blacks reside include New York City, Buffalo, Rochester, Syracuse and the Capitol District: Albany-Schenectady-Troy.

TABLE 1

Selected Population Characteristics in New York's Largest Cities, 1980

| | Population (Thousands) | Percent Black |
|---|---|---|
| New York State | 17,558.1 | 14 |
| New York City | 7,071.6 | 25 |
| Bronx | 1,169.0 | 32 |
| Kings | 2,230.9 | 32 |
| New York | 1,428.3 | 22 |
| Queens | 1,891.3 | 19 |
| Richmond | 352.1 | 7 |
| Buffalo | 357.9 | 27 |
| Rochester | 241.7 | 27 |
| Yonkers | 195.4 | 11 |
| Syracuse | 170.7 | 16 |
| Albany | 101.7 | 16 |

Source: 1985-86 New York State Yearbook, 12th edition (SUNY: Rockefeller Institute of Government, Year). Data based on 1980 Census of the Population, United States Bureau of the Census.

## Poverty Among Blacks

A preponderance of evidence underscores the insidious relationship between lower socio-economic status and ill-health. As will be discussed more fully later in this report, impoverishment relegates the poor in urban areas to substandard and overcrowded housing and environments, and lifestyles detrimental to their well-being: pollution, house fires, traffic hazards, asphyxiation resulting from faulty heaters, drug abuse and crime. Employment in low-wage jobs results in increased exposure to occupational risks and to toxic substances. In addition to these poverty-related factors, impoverishment also is accompanied by reduced access to preventive health services and to acute and long-term health care.

Data and analyses reported by the Department of Health and Human Services Task Force on Black and Minority Health (1985) reaffirm the relationship between income and health. The Task Force found that rates of disease decrease as income rises, leading them to conclude:

> ...income and education are major factors influencing health status. Lack of income and education must be recognized as risk factors for disease and death in Blacks.

For example, a review of social and health indicators for one New York community, the Fort Greene/Bedford-Stuyvesant area of Brooklyn, shows high proportions of Black residents and a majority of families with children under age 18 living in poverty. This community can also be described by its rates of low birthweight, infant mortality and deaths among children ages 1 to 14, which surpass the Statewide average (see table 2). Similar relationships can be found in other inner-city, predominantly Black areas -- both upstate and downstate. While researchers have been reluctant to state causal relationships between poverty and poor health, the data show clearly that a variety of indices of poor health are related to impoverishment. Thus, the statistics on poverty among Blacks in New York State take on added meaning.

# TABLE 2
## Social and Health Indicators
## Brooklyn: Fort Greene/Bedford-Stuyvesant

Pediatric Data: 1983-85

| Health Area | Total Population[1] | Percent Black[2] | Percent Poverty[3] | % Families with Children under 18 Below Poverty Level | Percent Medicaid Eligible[4] | Percent Low Birthweight[5] | Infant Mortality Rate[6] | Deaths to Children 1 - 14[7] |
|---|---|---|---|---|---|---|---|---|
| 13.00 | 12,209 | 86% | 32.4% | 57.8% | 31% | 13.5 | 27.9 | 9.3 |
| 14.10 | 13,612 | 58 | 43.1 | 65.7 | 48 | 13.5 | 18.2 | 7.4 |
| 18.00 | 8,099 | 64 | 40.7 | 66.4 | 51 | 12.8 | 33.0 | 4.3 |
| 19.00 | 12,360 | 66 | 54.8 | 65.7 | 53 | 14.7 | 19.6 | 7.2 |
| 20.00 | 16,635 | 97 | 36.4 | 47.8 | 44 | 13.6 | 34.2 | 5.4 |
| 21.00 | 11,950 | 93 | 35.1 | 52.1 | 41 | 13.1 | 21.4 | 7.4 |
| 28.00 | 20,375 | 96 | 36.7 | 48.4 | 35 | 13.2 | 26.7 | 10.2 |
| 30.00 | 21,927 | 96 | 29.8 | 43.4 | 32 | 12.4 | 20.5 | 11.9 |
| 31.00 | 15,252 | 93 | 42.5 | 60.6 | 45 | 13.1 | 23.2 | 6.5 |
| Total | 141,319 | 85.9% | 37.9% | | 40.3% | | | |

New York State, 1984:

Infant Mortality Rate: 11.0[8]
Percent Low Birthweight: 7.0%[8]

[1] 1980 Census
[2] Black/non-Hispanic
[3] 100% of Poverty Level
[4] As of October 1985
[5] As a percent of live births
[6] Per 1,000 live births
[7] Per 10,000 children 1-14 years
[8] Children's Defense Fund, 1987

Source: Regional Plan for Primary Care and Personal Preventive Services.

As shown in Table 3, Blacks of all ages are grossly overrepresented among the poor. Over 28 percent of New York State's Black residents had incomes in 1980 below the Federal Bureau of the Census definition of poverty, compared with 8.3 percent of white non-Hispanics who are poor. That is, more than one in four Black New Yorkers was poor; less than one in thirteen white New Yorkers was poor.

## TABLE 3

### Poverty Rates of Persons in the U.S. and New York, 1979
### Racial/Ethnic and Age Groups

### Total U.S.

| | Total | Children <18 | 18-64 | 65+ |
|---|---|---|---|---|
| Total Population | 12.4 | 16.0 | 10.3 | 14.8 |
| White, non-Hispanic | 8.9 | 10.0 | 7.6 | 12.5 |
| Black, non-Hispanic | 29.8 | 37.7 | 28.3 | 35.2 |

### New York State

| | Total | Children <18 | 18-64 | 65+ |
|---|---|---|---|---|
| Total Population | 31.4 | 19.0 | 9.6 | 11.6 |
| White,non-Hispanic | 8.3 | 10.1 | 5.3 | 9.8 |
| Black,non-Hispanic | 28.2 | 37.3 | 23.5 | 24.9 |

Source: NYS Department of Social Services Analyses of 1980 Census of Population; Vol. 1 Characteristics of the Population, Chapter C, General Social and Economic Characteristics. U.S. Summary and New York State volumes.

Poverty among Blacks in the major cities of New York is much more widespread than the State average for Blacks. The rate of poverty among Blacks in five of New York's major cities all exceed the Statewide average for Blacks. While more Blacks in poverty reside in the greater New York area, a greater proportion of Blacks upstate live in poverty. As table 4 shows, Buffalo leads the list in the percentage of Black individuals with income below the poverty level, followed by Syracuse and Albany.

**TABLE 4**
**Percent of Black and White Population Below Poverty Level**
**Major New York Cities, 1980**

| City | Percent of Black Population Below Poverty Level | Percent of white Population Below Poverty Level |
|---|---|---|
| Buffalo | 36 | 14 |
| Syracuse | 33 | 15 |
| Albany | 31 | 14 |
| Rochester | 30 | 11 |
| New York City | 30 | 13 |
| **New York State** | 28 | 9 |

Source: 1980 U.S. Department of Commerce, Bureau of the Census, Washington D.C.: Government Printing Office, 1980 Census of the Population.

The data in table 4 also show pronounced differences in the poverty rates of Blacks and whites across the State. Although the poverty rate of whites in these major urban areas is somewhat higher than the Statewide average, there are still wide disparities between Blacks and whites.

Poverty recognizes no age boundaries, and the State's Black children are at high risk for impoverishment. In 1985, more than two out of five Black children 18 years or younger in the State were growing up in poverty, an economic condition that bears heavily on their current health status, and also on their physical and mental development. While we are encouraged by the recent decline in the poverty rate among Black children, this progress is moderated by comparisons to other years (see table 5). For example, the poverty rate among Black children age 18 and younger in New York in 1985 (41.1 percent), was higher than it was in 1980 (36.8 percent).

TABLE 5

Poverty Rates Among Children 0-18, By Race, New York State

| Poverty Poor | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|---|---|
| White | 10.4 | 10.6 | 10.0 | 12.8 | 13.1 | 13.1 |
| Black | 36.8 | 40.4 | 43.0 | 36.9 | 42.2 | 41.1 |

Source: U.S. Department of Commerce, Bureau of the Census 1986.

Poverty among Black children under the age of 16 living in the major urban centers of the State reflect the same patterns of the Black population as a whole, only worse. That is, Black children living in inner cities, like Black adults in those communities, have higher rates of poverty than Black children Statewide. Table 6 shows, for example, that in 1980 one of every two Black children under 16 years in Buffalo lived in poverty. Further, the proportion of impoverished Black children in this age group who reside in Syracuse, New York City and Albany all exceeded the Statewide average for poverty among Black children.

TABLE 6

Percent of Black and White Children Under 16 Years in Poverty
Selected New York Cities, 1980

| City | Percent of Black Children Under 16 in Poverty | Percent of White Children Under 16 in Poverty |
|---|---|---|
| Buffalo | 50 | 20 |
| Syracuse | 42 | 19 |
| New York City | 41 | 22 |
| Albany | 40 | 16 |
| Rochester | 39 | 17 |
| New York State | 39 | 13 |

Source: U.S. Department of Commerce, Bureau of the Census.

## Concentrations of Poverty

Compared to the nation as a whole, New York has a much higher proportion of its poor population concentrated in urban poverty areas. A significant and growing number of Blacks are concentrated in these poor areas of the State. More than 3 in 4 poor Blacks (76.1 percent) in New York live in central city poverty areas--census tracks with poverty rates of 20 percent or more--compared to nearly 1 in 3 poor white New Yorkers (32.1 percent), and only 2 in 5 Blacks (39.6 percent) nationwide.

Concentrations of Blacks in poverty areas are even more severe in New York City than upstate. According to 1980 Census data, more than 86 percent of the Black poor in New York City live in communities where 20 percent or more of their neighbors are also poor. In fact, 45 percent of the Black poor in New York City live in areas where 40 percent or more are poor, compared to just 15 percent in 1970. Because access to health care is dependent largely on ability to pay and because physicians are less likely to practice in such poor areas, residents of these impoverished urban communities generally have access to fewer health care resources.

## Health Status of Blacks

While a host of factors influence health status, the literature on Black health suggests that four social characteristics are especially significant: (1) demographic profiles, (2) nutritional status and dietary practices, (3) environmental and occupational exposures and (4) stress and coping patterns (Secretary's Task Force 1985). Because Blacks tend to be overrepresented in each of the indices associated with poor health, the evidence showing higher mortality rates among Blacks in comparison with whites is appalling, but not surprising.

Of the two million deaths of Americans each year, approximately 12 percent are Black. In a major analysis of mortality data from 1979 to 1981, the U.S. Department of Health and Human Services (DHHS) analyzed primary contributors to the disparity in mortality rates among Blacks, other minority groups and whites. The DHHS Task Force on Black and Minority Health utilized the term "excess deaths" to describe the "difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the white population."

For Black males and females, the Task Force reports, almost half (47 percent) of the total annual deaths of those 45 years and younger and 42 percent of deaths in those 70 years and younger -- a total of 59,000 deaths annually -- are accounted for by excess deaths (Secretary's Task Force 1985). Six causes of mortality, taken together accounted for four of every five excess deaths of non-whites aged 70 and younger: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicides and accidents (unintentional injuries) and infant mortality. For those who died before age 45 in 1980, homicide and accidents, infant mortality, heart disease and stroke contributed the greatest number of excess deaths. Cancer, heart disease and stroke accounted for greater numbers of excess deaths for Blacks in advanced years.

Given the fact that these six factors account for such a large proportion of the differences in Black and white mortality rates, an overview of the effects of each disease on the nation's Black population will be presented. With some exceptions, the data are culled from national surveys. There is no reason to believe that the health of Blacks in New York differs significantly.

## Cancer

Blacks, and Black males in particular, have the highest overall age-adjusted cancer rates from both incidence and mortality of any U.S. population group (Secretary's Task Force 1985). Blacks experience greater age-adjusted incidence rates than whites for cancers of the cervix, esophagus, larynx, pancreas, prostate and stomach. National data collected over a thirty-year period, for example, show age-adjusted rates for esophageal cancer among Blacks three times higher than those of whites for the latest five-year period, 1976-1980. The mortality rate for Black men under the age of 55 was six times the mortality rate of white males in this age group. This condition among Blacks has worsened over the last three decades, with current rates nearly double those for Blacks in 1950 (Blot and Fraumeni 1987).

More than 70 percent of deaths from cancer of all types is accounted for by such major risk factors as tobacco, the combined effects of tobacco and alcohol, nutritional and dietary factors and occupation. Several risk factors help to account for the inequities in Black and white cancer incidence and mortality rates. Socio-economic status figures prominently in this disparity, as reported by the Secretary's Task Force (1985):

> Socio-economic status is related to a variety of factors which influence cancer experience, including: nutritional status; smoking patterns; distribution, quality and use of health resources; knowledge, attitudes and practices.

In addition to higher rates of incidence, there are striking differences in cancer survival rates, with fewer Blacks surviving a diagnosis of cancer. The medical literature suggests that these differences may be due largely to environmental factors rather than inherent genetic or biological differences. The factors cited include later stages of diagnoses, delay in detection and treatment and treatment differences (Secretary's Task Force 1985).

## Cardiovascular And Cerebrovascular Diseases

Average annual death rates for heart disease are higher for Black men and women under age 70 than for whites of comparable ages. While the mortality rates for coronary heart disease are similar in Black and white men, they show an excess among Black women compared to white women. Mortality rates due to hypertension are much more serious for both Black men and women.

Hypertension is a major risk factor for heart disease and stroke and the leading cause of kidney failure and hypertension-related end-stage renal disease among Blacks. In spite of growing public awareness, and progress in the treatment and control of hypertension among Blacks, there remain significant differences in mortality rates deriving from this condition. Stroke deaths are much higher among Blacks than among whites, 76.0 per 100,000 population for Black males and 41.2 per 100,000 for white males in 1979-81, and 60.2 compared to 34.7 per 100,000 for Black and white females, respectively. Obesity, common in Black women, may provide a partial explanation for excess risk of coronary disease among Black females (Secretary's Task Force 1985).

A variety of factors seem to account for differences between Blacks and whites on cardiovascular disease indices. The Secretary's Task Force (1985) provides the following summary of these factors:

> Dramatic differences exist between the levels of the various CVS (cardiovascular disease) risk factors both when minority populations are compared with each other and also when each is compared with the white population.

> The leading treatable risk factors for cardiovascular disease in the white population include hypertension, elevated blood cholesterol, cigarette smoking, diabetes mellitus and obesity. Although the data are limited or frequently nonexistent regarding these risk factors and their importance in minority health, current wisdom suggests that a major approach to improvement of cardiovascular and general health in minorities should focus on these modifiable risk factors. Major socio-economic differentials also exist between minorities and whites that affect their respective life experiences, biological risk factor distributions and access to medical care.

Further, differences between Blacks and whites on social, cultural and economic measures such as education, occupational level and income seem to influence their risk of disease. Behavioral factors such as poor diet, smoking patterns, residence in areas of high social stress, instability, styles of coping with stress and physical inactivity are often part of the socio-economic circumstances which increase risk for high blood pressure and cardiovascular disease.

## Chemical Dependency

In their review of data on Black excess deaths due to alcohol abuse, illicit drug abuse and cigarette smoking, the Secretary's Task Force reports higher rates of mortality among Blacks in comparison to whites. While chemical dependency mortality rates have declined consistently among all race and sex groups in the nation since 1973, these are still disproportionately higher among Blacks. The Black mortality rate for cirrhosis, for example, is nearly twice that of whites.

To the extent that Blacks are more likely to reside in inner-city areas where drug use is more prevalent than in rural areas, they may be at greater risk of drug abuse. The overall prevalence of drug abuse in the general household population, ages 12 and older, is about the same for Blacks as it is for whites. And, to the extent that Blacks are more involved in intravenous drug use, and thereby subject to increased risk of potentially fatal infections from hepatitus B virus, bacterial endocarditis and AIDS, the health consequences of drug abuse may be greater for Blacks (Secretary's Task Force 1985). Moreover, a study conducted by the New York City Police Department in 1981 and 1982 found that 53.1 percent and 46.4 percent, respectively, of drug-related homicides involved Black victims (New York City Police Department 1982).

Insufficient data are available on deaths due to overdoses of "crack," a cheap and highly addictive form of cocaine. "Crack," however, is a growing menace in Black inner-city communities across the State. Unfortunately, the problem is not limited to adolescents and adults. A growing number of babies of addicted mothers, many of them "boarder babies," are living the first months of their lives in hospitals because they are addicted and require supervised medical care or because their mothers are unable or unwilling to care for them, and there are no other placements available for caring for these babies.

## Homicides

Homicide is a leading cause of death among Blacks. In 1983, Blacks accounted for 43 percent of homicide victims, although only 12 percent of the population. Black males have the highest homicide rates and are almost seven times more likely than white males to be killed: 69.2 deaths per 100,000 Black males compared with 10.3 per 100,000 for white males in 1981. The data are even worse for Black males ages 25 to 34; 136.9 per 100,000 in 1981 compared with 17.6 for white males of the same age group. Over a lifetime, Black males have a 1 in 21 chance of becoming a homicide victim, compared with only 1 in 131 for whites (Secretary's Task Force 1985).

Black females are second only to Black males in homicide mortality rates. For 1981, the data show 12.9 deaths per 100,000 Black females compared to 31.1 among white females. That is, Black females have a 1 in 104 lifetime chance of becoming a homicide victim, compared to 1 in 369 for white females.

Blacks tend to die by the hands of other Blacks. In 1983, for example, 94 of every 100 Black victims were killed by Black assailants. Among Black youth aged 15 to 24, more than half (54 percent) of homicide victims were killed by persons known to them and more than 65 percent of these homicide deaths in 1979 were not related to criminal events (Secretary's Task Force 1985).

## Diabetes

Diabetes mellitus is one of the six major contributors of excess deaths in Blacks, especially in Black females. The prevalence of diabetes is one-third higher in the Black population than in the white population. The significance of diabetes as a health problem is increased because of its association as a risk factor for other major diseases: coronary heart disease and peripheral vascular disease.

On the differential effects of diabetes in the nation's Black population, the Secretary's Task Force (1985) reports:

> ...according to several studies,complications of diabetes are more frequent among the Black population of diabetics when compared with their white counterparts. The prevalence of macrovascular disease or large-vessel disease causing heart disease and stroke, and microvascular or small vessel disease, which

leads to kidney failure and blindness, appear to be more frequent among Blacks with diabetes than in whites with diabetes.

## Low Birthweight And Infant Mortality

Infant mortality is a tragedy that affects families across all racial and ethnic groups. While we have seen significant progress over the last three decades in lowering infant mortality rates among all groups in this country, a significant disparity between Black and white rates remains. Nationally, Black infants have twice the mortality rate of white infants: 20.0 versus 10.5 infant deaths per 1,000 live births in 1983.

Infant mortality is a significant problem in New York State as well. Progress has been made over the last two decades in lowering these rates to 11.0 per 1,000 live births in 1984 (Children's Defense Fund 1987). Communities with large numbers of Black residents, however, do not share these lower rates. The Black infant mortality rate for 1984 of 16.2 per 1,000 live births surpasses that for white infants 9.8 per 1,000 live births (Children's Defense Fund).

While New York City accounts for over 50 percent of infant deaths in the State, the city of Buffalo shows extremely high rates for infant mortality as well. For the years 1980-82, for example, the infant mortality rate for Blacks, and other minorities was in Buffalo 21.5 deaths per 1,000 live births, nearly double the Statewide rate for those years, and even higher than the rate of 17.1 per 1,000 live births for the same population in New York City. During this period, whites in the city of Buffalo had rates of only 10.4 per 1,000 live births (Health Systems Agency of Western New York 1981).

Low birthweight (less than 2,500 grams, or about 5 1/2 pounds) is also an important consideration here as it contributes to about two-thirds of nationwide mortality in the first month of life--about 60 percent of all infant deaths. National data show that among white infants, 5.6 percent are low birthweight as compared to 12.4 percent for Black infantss (Secretary's Task Force 1985).

An important strategy for lowering infant mortality is to improve the health services for poor pregnant women, especially pregnant teenagers. Pregnant Black women are less likely to receive prenatal care early in their pregnancy. In 1982, for example, 61 percent of Black mothers received care in the first trimester compared to 79 percent of white mothers. Furthermore, Black mothers were twice as likely as white mothers (10 percent vs. 5 percent) to receive either no care or care beginning in the third trimester of pregnancy (Secretary's Task Force 1985).

## Acquired Immune Deficiency Syndrome(AIDS)

Since the first recognition of the epidemic in 1981, Acquired Immune Deficiency Syndrome(AIDS) has become a killer of Black men, women and children. The numbers reported to the Centers for Disease Control tell a chilling story of the effects of this disease on Black communities. Of all AIDS cases reported from 1981 through September 1986, for example, 24 percent of 25,296 adult and adolescent cases and 58 percent of 334 pediatric cases nationwide were among Blacks (New York State Department of Health 1986). The statistics on incidence and mortality change almost daily. What remains constant is that each new set of data show higher numbers of persons with AIDS and that more than half of those who have been diagnosed with AIDS have died.

While the proportion of homosexual/bisexual AIDS patients has declined slightly over the course of the epidemic, this decline has been offset by a slight increase in the proportion of drug users with AIDS. Because half of Blacks with AIDS are heterosexual, the AIDS epidemic is spreading beyond the original subgroups most at - risk for the disease. This phenomenon stems from a larger population of intravenous (IV) drug users in New York and an overrepresentation of Blacks in that population. Thus, the share of New York's AIDS population that is Black is estimated to be greater than the national average.

AIDS has become a crisis in Black communities across the State, particularly in New York City. AIDS among Black heterosexuals not only affects the individual infected, it also has a devastating impact on whole families. The Centers for Disease Control estimates that Black women, contracting the disease via sex with a drug user or a bisexual man, are thirteen times more likely than white women to contract AIDS.

AIDS can also be transmitted from mother to child. Thus, the AIDS statistics on Black women directly relate to the AIDS statistics on children.

As no cure for AIDS is projected over the next decade, the only defense of Black and other communities is prevention. Denial of the risk of contracting AIDS by individuals in Black communities, coupled with the numbers of former drug users and bisexuals, place Blacks at grave risk of contracting AIDS. Perhaps partly out of fear of being identified with the problem, and/or lack of advocacy for IV-drug users and gays, and perhaps because of past stigmas of racial minorities as carriers of venereal disease, few organizations or leaders have taken on the issue of AIDS in Black communities. Targeted public information campaigns on AIDS, drug rehabilitation and safe-sex practices, however, will be especially important activities in Black communities.

In summary, what is telling about patterns of high morbidity and mortality among Blacks is that the conditions are preventable in some cases and treatable in others. These factors argue for a case-management approach to health services, with a strong emphasis on preventive medicine. Diabetes, hypertension and infant deaths are three examples of conditions striking Black males and females where early screening, diagnosis and a treatment plan could result in more positive health outcomes. The way in which poor Blacks access care--in hospital emergency rooms and outpatient departments, where attention is focused on the immediate, acute condition and not on the general health of the patient--tends to work against such prevention approaches and positive outcomes.

## Services: Access, Availability and Quality

In part, the health status differences observed between Blacks and whites can be attributed to several indices of health-care resources: health services utilization, health-care financing, availability of health-care facilities, personnel and health knowledge and behavior (Secretary's Task Force 1985). Most New Yorkers take for granted an available and accessible health-care system. Thousands of other New Yorkers, particularly in Black communities, however, do not share that reality.

While there are significant gaps in access to services and in the availability of health care in poor communities upstate and downstate, a few safety nets are in place. These include Medicaid and programs sponsored under its auspices, hospital emergency room and outpatient department services, community health centers and the School Health Demonstration Program.

Access to care in this nation is largely dependent on ability to pay for services. Because such large proportions of New York's Black population are poor, the Medicaid program provides important access to health care. There is little doubt that since enactment of Medicaid in 1966 we have seen marked improvements in the access and provision of health care to the poor. This joint state-federal health insurance program provides assistance to nearly 2.5 million New Yorkers annually who are unable to pay for medical services and who meet certain income and asset criteria.

While there is a tendency to treat the poverty population as if it were synonymous with the Medicaid population, Medicaid provides services to a specific group of people. Eligibility for the program is closely tied to participation in the State's public assistance programs -- Aid to Families with Dependent Children (AFDC), Home Relief (HR), the Supplemental Security Income (SSI) program -- and also to certain other eligibility criteria.

A variety of services are offered by New York's Medicaid program, including eight federally-mandated services: inpatient and outpatient hospital care; skilled-nursing care; laboratory and x-ray services; physician services; early and periodic screening, diagnosis and treatment of children; rural health clinic services; home health care services; and family planning services. In addition, New York also provides several "optional services," including dental care, personal care, drugs and sickroom supplies.

Data from the State's Medicaid program show the heavy reliance on clinics, emergency rooms and hospital outpatient departments for care by Medicaid recipients. Emergency rooms play a significant role in primary care services to Medicaid clients as a point of entry to the health-care system. Use of these services differs little by region, from a low of 26.1 percent in Nassau County to 29.4 percent in the Western Central counties (NYS Department of Social Services 1983). While emergency room and hospital outpatient department care in urban areas in particular provide access to treatment of acute conditions and fill part of the void in the health-care safety net, little in the way of basic health-care services, patient supports or coordinated health management are provided.

Blacks make fewer office visits to physicians than do whites (Aday and Anderson 1984), a pattern also seen among Medicaid clients in the State. In a study of providers of primary care to New York Medicaid clients, the State Department of Social Services (1983) reported wide variations.

## TABLE 7

### Percentage of Medicaid Primary Care Recipients by Types of Primary Care Providers, 1980-81

| Area | Type of Provider<br>Physician Only | Clinic Only | Physician and Clinic |
|---|---|---|---|
| New York City | 50.8% | 23.3% | 25.9% |
| Nassau County | 74.9% | 12.7% | 12.4% |
| Monroe County | 22.1% | 52.2% | 25.7% |
| Western Central Counties | 84.8% | 8.7% | 6.5% |

Table 7 shows that Medicaid clients in some upstate communities receive the majority of their primary care services from clinics. Medicaid recipients in New York City receive a relatively smaller share of their services from physicians but rely on the care provided by clinics. There is evidence to suggest, however, that the higher utilization of physician care in some areas of New York City is due to the number of Medicaid clients who receive services from physicians associated with Shared Health Facilities, a loose network of independent practicing physicians, many of whom have been identified as participating in medically abusive and fraudulent practices in New York City.

Total Medicaid expenditures for New York State in FFY 1985 amount to $7.3 billion. In response to spiraling medical costs and concerns about the quality and appropriateness of care Medicaid clients receive, several reforms in the name of cost-containment have been initiated since the 1970s. Chief among these are changes in the health care delivery system, moving away from fee-for-service arrangements to prepaid systems of managed care. Because of patterns in which Medicaid recipients tend to receive health services--clinics, emergency rooms, and hospital outpatient departments--the type of care they receive is likely to be episodic and fragmented, with little continuity and minimal emphasis on preventive care.

Capitation arrangements have seen rapid growth over the last few years. In capitation programs, the provider offers a range of health services for a prepaid, fixed monthly premium or rate, regardless of whether or not the patient uses those services. The influx of Health Maintenance Organizations (HMOs) has been a principal factor in the expansion of capitation arrangements in the State.

HMOs are relatively new participants in New York's health-care delivery system. In SFY 1982, for example, only a dozen or so HMOs operated in New York and few enrolled Medicaid clients. Both situations have changed over the last five years. As of March 1987, 28 HMOs were operating in various parts of the State. Because HMOs consider the availability of public transportation, population density and the number of physicians and health agencies serving the area, HMOs tend to be concentrated in downstate New York areas and in major urban regions upstate.

The number of Medicaid clients enrolled in these health organizations has also been on the rise, partly the result of a concerted effort by the State Department of Social Services. About 63,000 Medicaid clients were enrolled in five HMOs as of July 1986. Most clients were enrolled in the Rochester Health Network, the Genesee Valley Group Health Association Medicap Program in Rochester (over 41,000 Medicaid enrollees) and in the Health Insurance Plan of Greater New York in New York City (over 18,500 enrollees). Discussions between the local Department of Social Services and three HMOs are likely to result in Medicaid recipient enrollments in Erie County. The recent State Health Department requirement, that HMOs accept Medicaid clients, should facilitate enrollment of indigent New Yorkers in these organizations.

Enrollment in HMOs has the potential for bringing about several favorable outcomes for the poor. HMOs in New York State tend to operate as Independent Practice Associations. That is, private practitioners, with their offices as the primary care site, agree to provide HMO services to patients. HMOs have the potential to increase access to care in general, but particularly access to the services of individual physicians away from reliance on hospital emergency room and outpatient department care. Further, because HMOs have a vested financial interest in maintaining the health of those enrolled, they tend to emphasize case-managed health care and preventive medicine.

HMO expansion in the State can potentially bring more poor individuals into the practices of private physicians and into mainstream medical care. The extent to which this happens will depend in part on the number of Black doctors involved in the HMO, whether the HMO is located near a Black community and, because HMOs are reluctant to enroll clients whose health history would indicate greater need for care, the extent of Medicaid client enrollment.

Although HMOs are relatively new to New York's health-care delivery system, Black physicians, who tend to establish solo practices, have been slow in successfully developing HMOs, despite trends toward diversification and vertical service provision. The capital outlay necessary to form these organizations and the intense competition for individual enrollments, particularly employee groups, is not likely to alter this pattern in the near future. Expansion of HMOs, however, does raise important questions about where future Black doctors will decide to practice and with whom.

## Physician Participation In Medicaid

Enrollment in Medicaid, however, does not guarantee access to medical care. Depending on where one resides in the State, individuals eligible for Medicaid may not have access to physicians or to specialists who accept Medicaid clients. For example, just over 50 percent (54.2%) of all licensed, practicing physicians billed Medicaid during FFY 82, somewhat overrepresenting State physician involvement in the program because of the limited services rendered by most of these physicians. Analyses reported by the State (NYS Department of Social Services 1984) show that Statewide only 4.6 percent of the available physician workforce participates in Medicaid, while those eligible for Medicaid represent 15.1 percent of the State's population.

Care provided by primary care physicians to Medicaid clients varied from a Statewide figure of 17.1 per 1,000 Medicaid eligibles, from a low of 4.3 physicians in New York City to a high of 15.9 in suburban New York in FFY 82. Participation of primary care providers per 1,000 Medicaid eligibles upstate ranged from 8.2 to 12.5 physicians (NYS Department of Social Services 1984).

Part of the problem of low physician involvement stems from the low maximum reimburseable fees allowed under Medicaid, rendering specialist care, particularly obstetrical and gynecological care with high malpractice insurance rates, almost inaccessible to poor women in some parts of the State. Because of these low fees, reputable Black doctors are beginning to walk away from practices in poor communities.

## Medicaid Reform

The Medicaid Reform Act was the first step of a long-term strategy designed to lead to improvements in accessible, comprehensive and quality health care for Medicaid clients, and to slow the rate of growth in Medicaid expenditures. Although New York had been experimenting with new ways of managing health care for several years, the Act provided opportunities to test various alternatives to the fee-for-service system, affecting financing and service delivery patterns, as well as provider, patient and payor relationships.

While the Medicaid Reform Act is a broad piece of legislation, major sections provide the State Department of Social Services and Health Department with authority to broaden the health-care options for Medicaid beneficiaries. These demonstrations include Prepaid Health Services Plans (PHSPs), Physician Case Management Programs (PCMPs) and Health Maintenance Organizations (HMOs). PHSPs are community health centers and hospitals that have signed, or are about to sign, contracts with county departments of social services to assume financial risk for the provision of health services to Medicaid clients. In contrast, PCMPs are prepaid risk contractors consisting entirely of physicians in private practice. PCMPs were developed to boost the extremely low participation level of physicians in the Medicaid program.

In the last two years, the Department of Social Services has devoted considerable resources to implementing the Medicaid Reform Act. Eight of nine Prepaid Health Services Plan programs serving Medicaid recipients are in the final stages of development, and will offer a range of comprehensive health services on a prepaid, contractual basis. The first of these programs began operation in

February 1987. Four PCMPs are in the development process and currently five HMOs in New York State provide health services to 63,000 Medicaid clients.

For 1988, the goal is to enroll more than 8 percent of all Medicaid-eligible individuals in prepaid, managed plans. This is an ambitious plan. By 1990, New York State expects program enrollment to grow to nearly 333,000 clients, 15 percent of the Medicaid caseload. To achieve these goals , the major thrust will be on expanding the number of Medicaid clients served by HMOs, as well as increasing client enrollment in PHSPs and PCMPs.

## Child/Teen Health Services

Preventive care, an important health service for all age groups, is especially important for children. The State Department of Social Services has been particularly concerned about underutilization of Medicaid services among children. To encourage preventive care for this age group, the State Department of Social Services' Child/Teen Health Plan provides comprehensive screening, diagnostic and treatment services to all Medicaid-eligible children under the age of 21. This New York State version of the federal Early and Periodic Screening Diagnosis and Treatment program, required by Title XIX, obligates State Medicaid agencies to identify all children in this age category and to assist them in attaining needed health services.

Only 14 percent of eligible children used the Child/Teen Health Services in 1982. Renamed and revised in 1984 to facilitate the involvement of medical providers and recipients, several changes have significantly increased the effectiveness of the program. These changes included a new periodicity schedule to include more comprehensive examinations, an increase in physician fees and the use of the State Department of Social Services' information systems to directly notify parents that their eligible children had not received any medical services in at least a year. This notification explains the benefits of receiving regular checkups, and suggests that parents notify their local social services district for assistance. In the first year of these changes, the number of physical examinations conducted and preventive services to children increased from 62,000 to nearly 150,000, almost 134 percent. The program has been growing ever since.

In 1986, more than 475,000 letters were mailed to families with Medicaid-eligible children and teens informing them of the availability of Child/Teen Health Plan services. In addition, the State Department of Social Services notifies local districts of those Medicaid recipients aged 0 through 5 who have not had any paid medical services within the previous twelve months. Local district staff then contact the families of these children and re-offer the services of the Child/Teen Health Plan. Plans are underway by the State to expand the involvement of dental providers through promotional campaigns to all New York State licensed dentists. Evidence shows that the program is an effective intervention for reaching this population of poor children. Of particular note is the significance of follow-up strategies.

## Community Health Centers

Community Health Centers (CHCs), formed two decades ago, are a major link in the chain of programs developed at the national level to address the plight of the nation's poor. CHCs offer an additional source of accessible medical care in poor neighborhoods. These community-based facilities provide a full range of comprehensive health services to individuals of modest means who might otherwise be forced to go without health care. They also are important community resources, providing employment opportunities and vital health services. CHCs are funded by the federal government under authority of Section 329 and 330 of the Public Health Act.

Presently, close to 50 Community Health Centers operate throughout New York State. Most are concentrated in the New York City region and the thruway cities of Albany, Schenectady, Syracuse, Rochester and Buffalo. In all, they treat more than a half million patients per year, one-third of whom are Medicaid eligible. Given their mission to serve low-income residents and their geographic proximity to large pockets of Medicaid-eligible clients, Governor Cuomo chose this delivery model, along with Health Maintenance Organizations and private-practicing physicians, as a cornerstone of his 1984 Medicaid Reform initiative.

Because Community Health Centers already operate in federally designated Health Manpower Shortage Areas, they have become an important vehicle addressing the needs of the poor and otherwise uninsured. They have demonstrated an ability to deliver high quality health service care and have consequently received additional financial support from New York State over the past few years.

## School Health Demonstration Program

A health-care safety net is provided for thousands of children and adolescents in heavily Black-populated neighborhoods in Buffalo, Rochester and areas of New York City through the School Health Demonstration Program (SHDP). Since the beginning of SHDP a few short years ago, 93 health clinics -- 14 upstate and 79 downstate -- provide a comprehensive array of health services to more than 40,000 youth at the school site, from preschoolers to high-school-age students. Services range from all areas of immunization to family planning.

SHDP clinics are a national phenomenon with a relatively short history. Their impetus grew out of recognition that many children, for a variety of reasons, were not receiving the level of preventive health services and treatment necessary to ensure healthy development. In an effort to affect as many children as possible, it became clear that the most effective approach was to locate the services in convenient places where children and adolescents are likely to spend most of their waking hours--at school.

New York, like many other States, contracts with Community Health Centers to provide these important services. Baseline projects as of June 1986 included:

Boriken Neighborhood Health Center
Brownsville Neighborhood Health Center
Bronx-Lebanon Consortium
Downstate Medical Center
Harlem Hospital
Hunts Point Neighborhood Health Center
Jamaica Hospital (elementary)
Anthony L. Jordan
Lutheran Medical Center
Lyndon B. Johnson Neighborhood Health Center
Geneva B. Scruggs

Adolescent projects are provided by the following agencies and hospitals:

Bedford-Stuyvesant
Jamaica Hospital (adolescent)
Mt. Sinai Hospital
Ryan Neighborhood Health Center
St. Luke's - Roosevelt Hospital
Threshold Adolescent Center, a subcontractor of
  Anthony L. Jordan

Significant portions of the school population are enrolled at each site. As of June 1986, for example, more than 75 percent of the student population was enrolled in SHDP. The adolescent projects, all but one of which began operation in January 1985, have enrolled over one-third of the student populations after one year. In fact, from January 1985 to June 1986, adolescent project enrollment has more than tripled, from 2,217 to 6,688 students, and visits to the clinics have increased well over 300 percent.

The magnitude, growth and nature of the services rendered by all the projects is reflected in the numbers enrolled and types of services received. For the school year ending in June 1986, students made more than 31,500 primary and episodic care visits to the clinics for nearly 140,000 encounters. More than 5,400 of these visits were for management of chronic illnesses; nearly 11,800 were for complete physicals; and more than 2,600 visits were for immunizations. The nature of other visits were distributed as follows: 754 psychosocial visits, 37,718 visits for first aid, 7,738 counseling visits, 35,462 health education sessions, 914 dental visits, 16,237 follow-up visits and 7,811 off-site referrals.

While some controversy over the dispensing of contraceptives to adolescents has surrounded the School Health Demonstration Program, it is clear that these school-based clinics provide a critically important function in making health services available to these populations of poor students. Two factors help account for the success of the program. First, with parental consent, enrollment in the program is available to all students and enrollment in the program is a simple process. Second, the services are easily accessible. The clinics have succeeded in establishing a visible and viable presence at the school sites, extending health services to thousands of poor youth.

## Uninsured

Not all who are eligible for Medicaid take advantage of the services provided under the program. In FFY 1985, for example, approximately 16 percent of New Yorkers eligible for Medicaid did not use those services.

Far too many other poor are left uncovered by Medicaid. In New York, about 40 percent of the poor are not enrolled in the program. And as family size increases, more typical in Black families than in those of whites, there is a wider gap between the poverty level and Medicaid eligibility.

To be without health insurance in today's society of high-cost health care means to be without medical services. As participation in health insurance plans rises with income, large numbers of poor and low-income families and individuals are excluded from this category. Estimates suggest that approximately 400,000 poor persons in New York State, including 100,000 poor children, are not covered by Medicaid or by private insurance. An additional 340,000 persons with incomes just above the poverty level fall into this same gap in health coverage.

Those who are poor and near poor and not eligible for Medicaid have few options when faced with a medical emergency. Among the thousands of New Yorkers who lack health insurance are the working poor who are not eligible for Medicaid, but because they work part-time or in low-paying jobs they are without health-care coverage. These individuals and their families must either forego medical-care, pay out-of-pocket or draw upon free sources of care. Their limited disposable income forces them to delay medical treatment, a behavior, some researchers report, that accounts for the poorer prognoses among Blacks for certain illnesses (National Cancer Institute 1985) or to rely on charity for their medical and hospital care.

## Bad Debt And Charity Cases

The medically indigent population is growing. As Blacks can be presumed to be overrepresented among this group, bad debt and charity care is an important consideration in any discussion of the status of health and health care for Blacks in New York. Large, city public hospitals are the major providers of care to the poor. The United Hospital Fund (1985) raises a key question regarding provision of services and care to the poor: "Regardless of a community's economic condition, can hospitals committed to serving the poor be relied on to maintain or expand that mission?" New York's answer to that question will be an important one for Black communities in the State.

In part as a response to that question, the State established in January 1983 the New York Prospective Hospital Reimbursement Methodology (NYPHRM). Basically, this is a mechanism by which to distribute a State pool of funds to hospitals that provide bad debt and charity care for hospital inpatient services. In 1986, the Statewide bad debt and charity pool totaled $258 million, 4.5 percent of all hospital inpatient services. The pool for 1987 has been set at the same rate, 4.5 percent, and totals $266 million. Of the $266 million, major public hospitals will receive $70 million, including $49.7 million to go to the New York City Health and Hospitals Corporation. New York City voluntary hospitals will receive just less than half of the total pool, $126 million.

## Diagnostic-Related Groups (DRGs)

Implementation of Diagnostic-Related Groups (DRGs) in the Medicare program in 1983 raises a host of issues that may negatively affect the Black elderly. DRGs are intended to provide a guide for length of hospital stay for some 468 specified diagnoses. They do not, however, account for the severity of the illness. Because hospitals lose money when a patient remains hospitalized beyond the average stay specified for the illness he or she may have, DRGs may be providing strong incentives for hospitals not to treat poor patients or to pressure doctors for too-early release of patients.

While NYPHRM attempts to distribute more equally the burden of hospitals for providing care to the poor, DRGs may also be limiting the amount of charity care hospitals can provide. Hospitals perceive that they may no longer be able to afford the quantity of free care that they were able to provide before implementation of DRGs. Thereby, DRGs have the potential of leaving the voluntary hospitals and public institutions, such as the New York City Health and Hospitals Corporation, to provide an important safety net of health care for the poor. Concerns have been raised about the quality of care in these institutions, yet they provide important services in Black communities.

## Care For The Black Elderly

An entire section of the Subcommittee's report is devoted to health-related issues of the Black elderly in New York State in recognition of the fact that insufficient attention has been paid to this population in the past. The Subcommittee placed primary emphasis on both the need for increased availability and access to community-based supportive services, in particular homecare and long-term care. However, access to long-term care beds for Blacks is an issue that warrants increased emphasis and is, therefore, addressed briefly here.

As the numbers of Black elderly continue to rise and the ability to care for our aged at home decreases, consideration must be given to the need for suitable alternatives. The history to date has not been encouraging.

In January 1984, the Friends and Relatives of the Institutionalized Aged (FRIA) released a report citing broad discrimination practices in New York City nursing homes. The report revealed that although minorities as a whole represented a total of 18.4 percent of the city's residential health-care facility beds, they were largely overrepresented in public nursing homes where they occupy close to 50 percent of the beds. Most of the "better" voluntary and proprietary nursing homes had only token or no minority occupants at all.

Although many possible reasons for this phenomenon exist, including legal ability to discriminate on the basis of religion, there is one problem that must not be overlooked. In virtually every nursing home, preference in admission goes to the private-paying patient, as opposed to those covered by Medicaid. The reasons given include the length of time necessary to confirm Medicaid eligibility for individuals applying for Medicaid, and the lower reimbursement rate for eligible patients. It is customary for nursing homes to charge private-paying patients a higher daily rate until they "spend down" or exhaust their private funds. It is only then that application for Medicaid is encouraged. The irony of the situation is that the entrenched poor, identified by their long-term Medicaid membership, and largely overrepresented by Blacks and other minorities, are being discriminated against in favor of the "nouveau poor," who are more likely not to be minority. In light of the fact that Medicaid payments support 80 percent of all nursing home beds in New York State, it is not unreasonable for the State to require equal treatment vis-a-vis admissions practices.

In response to the FRIA report, the New York State Nursing Home Task Force was formed in 1984. Among its many recommendations designed to eliminate discrimination is the following:

> It is recommended that legislation be enacted which would prohibit nursing homes from discriminating against a patient or against an applicant for admission as a patient, on the basis of the patient's source of payment for nursing home fees and charges.

## Preventive Care

The importance of preventive care is underscored in all of the data on health conditions cited above. Much of that discussion, and the sections on available and accessible services, show the need for and responsibility of institutions and agencies to broaden the health resources and availability of care. This section of the Subcommittee's report has presented the Governor's Medicaid Reform strategy for developing a systems approach that fosters preventive medicine and discourages episodic and fragmented care, as well as discussion of the

Child/Teen Health Program, Community Health Centers and the School Health Demonstration Program. Each of these are important strategies for expanding access to preventive care.

Individuals and families also share responsibility for utilizing the health systems network in a way that focuses on prevention rather than on acute conditions. Knowledge, attitudes, cultural factors and past practices all influence the way people view their illnesses and the medical attention they may or may not seek. The data show, for example, that Blacks are less knowledgeable about cancer-related warning signs and screening methods than whites, and are more pessimistic about the curability of cancer than whites (Secretary's Task Force 1985). These and similar attitudes and lack of understanding may help to explain the longer delay in seeking diagnosis and treatment among Blacks and, thus, the greater prevalence of more advanced stages of cancer in Blacks than whites (National Cancer Institute 1985). Public health and information campaigns focused on a variety of behaviors -- smoking, diet, the importance of prenatal care and preventive services, safer sex, timeliness in seeking medical care and so forth -- in targeted areas of the State are perhaps as important activities for preventive health care as the institutional responses. Cultural compatibility of services is imperative.

## Human Resources In Services Delivery: Who Will Provide the Services?

In comparison to prior decades, more physicians are serving this country's population, a trend expected to continue through the end of this century. National data show consistent increases in the ratio of physicians to population. From 140 physicians per 100,000 population in 1950 to 200 physicians in 1980, projections show an increase to 235 physicians by 1990 and to 260 physicians per 100,000 population by the year 2000. In terms of physician supply, New York State will fare even better. If current projections hold, estimates of 330 physicians per 100,000 population by 1990 will exceed the national average (Meyers, Edelstein, Rogatz and Sabou 1986)

During the 1960s and early 1970s, expanding the supply of physicians was a top national priority, reflected in part by federal financial support and other incentives. Medical school enrollment nationwide almost doubled, growing from 8,772 first-year medical students in 1963-64 to 16,000 in 1977-78. Significant growth in the number of physicians was felt in New York as well. In large part because of its concentration of medical schools, major medical centers and research facilities, the number of physicians in New York State increased from 17,100 to 48,700 between 1960 and 1980, about one-third higher than the national average (Meyers et al., 1986). At the same time, a number of U.S. graduates of foreign medical schools returned to practice in the State.

Federally sponsored programs and incentives from 1964 to 1974 also brought significant progress in expanding opportunities in health careers to minorities. Black enrollment in medical schools increased sharply: from 1,042, or just 2.8 percent of total enrollment in 1969-70, to 3,884, or 5.9 percent of total enrollment by 1981-82.

Black women were important beneficiaries in this enrollment growth, comprising nearly 45 percent of Black medical students in 1983-84, compared to just 20 percent in 1971-72. Despite the surge in medical school enrollment, the number of Black physicians practicing nationwide only rose from 2.1 percent in 1950 to 2.6 percent in 1980 -- 4,026 to 11,700 physicians -- or from 27 to 42 Black physicians per 100,000 Black population (Meyers et al., 1968; Shea and Fullilove 1985).

Although there is a growing physician surplus in the State, low-income urban areas still face physician shortages. To provide a benchmark by which to assess physician shortages, the federal government defines a health manpower shortage area as one having less than one doctor per 3,000 residents. In New York State portions of every major urban Black community are designated health manpower shortage areas.

In the greater Harlem community, for example, there was less than one physician per 4,000 residents in 1978. The ratio of physicians to population within the boundaries of zip codes 10035 and 10026 in East and Central Harlem was less than one physician per 7,000 residents and 6,000 residents, respectively. By 1980, the ratio in these two areas worsened, falling to one physician per 15,000 residents (Meyers et al., 1986). In terms of physician-to-population ratios, residents in these medically underserved areas were about 36 times more disadvantaged than individuals residing in New York City as a whole (Meyers et al., 1986).

## Who Will Serve Black Communities?

Several conditions mediate the availability of health care in Black communities around the State. First, most urban, low socio-economic and predominantly minority areas of the State will continue to experience a chronic shortage of physicians. From 1940 to the 1970s, the number of Black physicians in New York State more than tripled, from about 300 to 1,069 (Watts and McCormack 1985). This growth, however, did not keep pace with increases in the State's Black population over the same period. As a result, the ratio of Black physicians to Black New Yorkers decreased from 1:1904 in 1940 to 1:2029 in 1970, compared to an overall State physician-to-population ratio of 1:477 in 1970 (Watts and McCormack 1985).

Expanding the supply of Black physicians and other health professionals is an important priority for those concerned with improving the availability of health care in Black communities of New York State. The cause for concern stems from observations and the data on where physicians choose to practice. Like physicians in other parts of the nation, doctors in New York are more likely to establish practice in wealthier neighborhoods and near academic medical centers than in low socio-economically depressed, inner-city communities (Meyers et al., 1986).

There is growing evidence that doctors from minority backgrounds are more likely to serve patients of the same background. They are also more likely than whites to practice in medically underserved areas; to treat Medicaid patients; and to choose such primary care specialties as family practice, general internal medicine, general pediatrics and obstetrics-gynecology (Keith, Swanson, Bell & Williams, forthcoming; cited in Meyers et al., 1986).

One avenue for promoting medical practices in inner-city communities is the Federal National Health Service Corps. In response to the few numbers of physicians electing to practice in inner-city and rural areas and in light of the national priority to expand the supply of physicians, the Federal government initiated several programs to fill these voids:

> Federal efforts aimed at improving the distribution of physicians have included the 1976 National Health Manpower Act, Loan Repayment and Scholarship programs, Area Education Centers and the National Health Service Corps (NHSC). Special funds have been made available for training programs in family practice, general internal medicine, and general pediatrics (Meyers et al., 1986).

The National Health Service Corps (NHSC) aims to provide both short-term and long-term remedies to physician availability in medically underserved areas. On the one hand, in exchange for medical school financial support, physicians are expected to practice for two years in a medically underserved area. There is also some expectation that once physicians become members of these communities, they will elect to continue residence and practice there.

Evaluations of the rural component of the NHSC program speak to its success. A study of the program conducted by the Health Resources and Services Administration reported that more than 70 percent of NHSC alumni settled in the same rural areas where they had fulfilled their NHSC obligations, compared to only 4 percent of all primary care graduates who settled in rural underserved areas. No comparable studies or data are available, however, on the settlement of NHSC alumni in inner-city areas (Meyers et al., 1986).

Several agencies and organizations have examined a variety of factors to determine the variables that influence physician choice of location. The findings appear to be consistent across studies. Black doctors tend to practice in Black communities. In their 1982 publication, Physician Manpower Survey 1980-81, for example, the New York State Education Department reported that race/ethnicity was a key variable influencing in where physicians decide to set up practice. The data show that the location of the medical practices of Black and other minority physicians mirrors the geographic distribution of the State's racial and ethnic population.

There is no reason to expect this trend to change given the attitudes of medical school graduates. Survey results published in 1982 by the American Medical Association reported that 75 percent of minority graduates would consider practicing in low socio-economic areas, compared to only 49 percent of non-minority graduates who would consider such a practice. It is unclear from these and other data whether the tendency of Black physicians to practice in predominantly Black communities is influenced by de facto segregation, economic barriers or other obstacles that tend to reinforce existing patterns. What is clear is that, at least in the short-term, this pattern seems likely to continue.

Because Black physicians tend to practice in Black communities, the availability of health services in these communities will be affected by the number of Black physicians and allied health professionals in the State. Unless measures are taken now, Blacks will continue to be grossly underrepresented among physicians and other health professionals: dentists, optometrists, pharmacists, podiatrists and registered nurses, as well as allied health personnel, who complement the delivery of health care and services to patients.

## Increasing The Supply Of Black Physicians: Medical School Graduates

Black graduates of most professional health programs slightly increased numerically but remained relatively stable proportions of medical school graduates nationwide between 1976 and 1981. In fact, the percentage of minority students entering and graduating from medical school hardly changed between 1974-75 and 1983-84. In part, these trends reflect a questioning of affirmative action spurred by the *Bakke* and *deFunis* court decisions (Shea and Fullilove 1985). Substantial proportionate increases, although very small numbers, were reported only in the field of podiatry (The College Board 1985).

## TABLE 8
### First Professional Degrees Awarded to Blacks by Medical Discipline, United States: 1976, 1979 and 1981

| Discipline Division | 1976 Blacks | 1976 Percent of Total | 1979 Blacks | 1979 Percent of Total | 1981 Blacks | 1981 Percent of Total |
|---|---|---|---|---|---|---|
| Total | 950 | | 1,010 | | 1,040 | |
| Dentistry | 181 | 3.3 | 180 | 3.3 | 195 | 3.6 |
| Medicine | 708 | 5.3 | 762 | 5.2 | 767 | 5.0 |
| Optometry | 14 | 1.4 | 12 | 1.1 | 9 | .8 |
| Osteopathic Medicine | 12 | 1.5 | 18 | 1.7 | 16 | 1.4 |
| Pharmacy | 6 | 1.4 | 16 | 2.5 | 20 | 3.0 |
| Podiatry | 3 | .7 | 15 | 2.6 | 20 | 3.4 |
| Chiropractic Medicine | 26 | 1.6 | 7 | .4 | 13 | .6 |

Source: National Center for Education Statistics, Participation of Black Students in Higher Education: A Statistical Profile from 1970-71 to 1980-81, November 1983.

In in New York, both the number and proportion of Black medical school graduates have declined continually since the 1981-82 school year. As shown in table 9, the numbers and share of the State's medical school graduating class in 1984-85 who are Black and other minorities -- mainland Puerto Rican, Mexican American and Native American -- has been falling consistently since the 1981-82 school year, and are now at levels below those reported for 1980-81. Further, the data in table 9 show that the percentage of medical school graduates who are minorities in New York State falls significantly below the national average for Black medical school graduates.

### TABLE 9
### Minority Graduates of New York State and U.S. Medical Schools Number and Percent of Graduating Class, 1980-1984

| | 1980-81 | 1981-82 | 1982-83 | 1983-84 | 1984-85 |
|---|---|---|---|---|---|
| U.S. Medical Schools | | | | | |
| Total Minority * Graduates | 1086 | 1114 | 1231 | 1191 | 1224 |
| % of Graduating Class | 6.9 | 7.0 | 7.8 | 7.3 | 7.5 |
| New York State Medical Schools | | | | | |
| Total Minority Graduates | 82 | 110 | 91 | 88 | 88 |
| % of Graduating Class | 4.9 | 6.2 | 5.2 | 4.9 | 4.7 |

* Blacks, mainland Puerto Ricans, Mexican-Americans, Native-Americans

Source: American Association of Medical Colleges, 1983.

## Medical School Enrollment

Although the numbers of Black students enrolled in medical school have increased since 1969-70, when only 2.8 percent of the nation's 37,690 medical school students were Black, Black enrollment still falls far short of parity with white enrollments (Association of American Medical Colleges 1984). Blacks comprised just 5.9 percent of the total U.S. medical school enrollment of 66,298 in academic year 1981-82 and 6.8 percent in 1983-84. Unless actions targeted to this problem are implemented, the figures will continue to be modest.

New York falls below the national average in enrollment of Blacks and other minority students in medical school programs. In fact, the Health Careers Network, which publishes data on minority enrollment in the nation's medical schools, reported that not one New York medical school in 1982-83 was among the top fifteen schools on this indicator.

In a review of the status of Black medical school applicants and enrollments in New York, Cave (1982) provided this assessment:

> New York medical schools fall below the national average in the percentage of minorities who enroll in their programs. They also rank low in the percentage of minority applications. While the pool of applicants is a factor in recruiting minorities, the fact remains that medical schools in New York State are not getting their share of even the limited number of minorities who apply to New York medical schools. This suggests that increasing the pool of minority applicants alone will not necessarily increase New York's share of minority admissions.

Of approximately 1,390 new entrants to medical schools in New York State for the 1985-86 academic year, for example, only 5.9 percent, just 82 students, were Black (American Association of Medical Colleges 1983). And because doctors tend to practice near the same areas in which they are trained, we are unlikely to see an influx of Black doctors from other States to fill this void.

The State's public institutions report higher enrollments of Blacks in medical school than do private institutions: 4.9 percent in nonpublic medical schools vs. 7.3 percent in State University of New York medical schools. The figures still show an overall gross underrepresentation of Black medical students in the State.

## Dentistry

As in the case of physicians, severe shortages of dentists practicing in socio-economically depressed areas and Black communities of New York raise concerns about the availability of dental services and care. In fact, dentist-to-population ratios are so low in several of these communities as to qualify them as Federal Dental Manpower Shortage Areas. The December 1981 New York State Dental Journal described evidence of a significant maldistribution of dental care in New York City:

Eighty-five of the health areas of New York City (25 percent) had general practitioner dentist-population ratios at or below 0.20 dentists per 1,000 population, the federal level used to indicate a dental manpower shortage area. Brooklyn and the Bronx had 62 of these health areas with ratios of 0.20 or fewer dentists per 1,000 population. Twenty-four of the city's health areas were found to have no dentists in practice at all. Eleven of these were located in the borough of the Bronx.

## Allied Health Professionals

Similar patterns of underrepresentation can be found for almost every health profession. Table 10 shows minority enrollment at State University of New York (SUNY) schools and in community colleges in 1982 and 1984 for selected health professions: nursing, dental hygiene, pharmacy, physical therapy, occupational therapy and physician's assistant. While the data only reflect the SUNY system, they are disappointing and reflective of a much greater problem. All of the professional training programs in health show minority enrollments of less than 10 percent. Indeed, most programs show such enrollments below 5 percent..

## TABLE 10
## SUNY Minority Enrollments
## Selected Health Professions: Schools and Community Colleges
## 1982 and 1984

| | All Students | Minorities* | |
|---|---|---|---|
| | | Number | Percent |
| **Nursing** | | | |
| 1984 SUNY Operated Institutions | | | |
| Masters Degree | 439 | 9 | 2.1 |
| Bachelors Degree | 2,164 | 195 | 9.0 |
| Associate Degree | 811 | 23 | 2.8 |
| Total | 3,414 | 227 | 6.6 |
| Community Colleges Associates Degree | 6,580 | 563 | 8.6 |
| State University Total | 9,992 | 790 | 7.0 |
| 1982 SUNY Operated Institutions | | | |
| Masters Degree | 390 | 11 | 2.8 |
| Bachelors Degree | 2,248 | 175 | 7.8 |
| Associate Degree | 892 | 38 | 4.3 |
| Total | 6,432 | 410 | 6.4 |
| State University Total | 9,962 | 634 | 6.4 |
| **Dental Hygiene** | | | |
| 1984 SUNY Operated Institutions | 151 | 2 | 1.3 |
| Community Colleges | 451 | 12 | 2.7 |
| State University Total | 602 | 14 | 2.3 |
| 1982 SUNY Operated Institutions | 124 | 4 | 2.8 |
| Community Colleges | 445 | 14 | 3.1 |
| State University Total | 587** | 28 | 4.8 |
| **Pharmacy** | | | |
| 1984 Bachelors Degree | 241 | 5 | 2.1 |
| First Professional Degree | 22 | 1 | 4.5 |
| Total | 263 | 6 | 2.3 |

TABLE 10 - Continued

| | | | |
|---|---|---|---|
| 1982 Bachelors Degree | 236 | 5 | 2.1 |
| First Professional Degree | 5 | 1 | 6.7 |
| Total | 251** | 6 | 2.4 |
| **Physical Therapy** | | | |
| 1984 SUNY Operated Institutions | 254 | 12 | 4.7 |
| 1982 SUNY Operated Institutions | 257 | 9 | 3.5 |
| **Occupational Therapy** | | | |
| SUNY Operations Institutions | | | |
| 1984 Bachelors Degree | 175 | 12 | 6.9 |
| Masters Degree | 6 | 0 | 0.0 |
| Total | 181 | 12 | 6.6 |
| **Physician's Assistant** | | | |
| 1984 SUNY - Bachelors Degree | 51 | 3 | 2.1 |
| Community Colleges | 55 | 1 | 1.8 |
| Total | 106 | 4 | 3.8 |
| 1982 SUNY Bachelors Degree | 48 | 2 | 4.2 |
| Community Colleges | 55 | 2 | 3.6 |
| Total | 103 | 4 | 3.9 |

* Includes Black Americans, American Hispanics and Native Americans
** Sums do not equal total

Source: SUNY Office of Institutional Research and Planning.

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Three issues are key to increasing the number of Black medical school graduates in the State: increasing the pool of applicants, increasing the rate of acceptance and retaining more students enrolled in medical school programs. While the total number of all applicants to medical schools declined and the overall acceptance rate increased over the last several years, different outcomes have been experienced by minority applicants. Cave (1982) reports:

> Nationwide data from the AAMC (Association of American Medical Colleges) indicate a downward trend in the total number of medical school applicants. Since 1974-75, the peak year for medical school applicants nationally, total applicants have decreased. In contrast, the same nationwide data indicate that the number of minority applicants to medical schools increased during the same period. This was not true for New York State where, since 1978, the number of minority applicants has decreased.

While medical school minority applications increased nationally, medical schools were accepting a smaller proportion of minority applicants, acceptance rates that are in fact below that of the general applicant pool (USDHHS 1984). After 1974, the acceptance rate for Black applicants declined, at the same time that rates for whites increased and have been higher than that for Black applicants since 1978 (Shea and Fullilove 1985). The result was that proportionately fewer Black and other minority individuals were accepted into medical school programs. Such data argue that proportionately lower Black medical school enrollments cannot be explained by trends in fewer applicants.

In an analysis of affirmative action in medical schools, Manard and Lewin (1983) report on projected numbers of minority physicians based on current practices:

> Research ... strongly indicates that in the absence of a deliberate effort, the number of Blacks who apply, are accepted and graduate from U.S. medical schools will not increase substantially (Watts & McCormack 1985).

Financial aid has a great effect on college retention rates, particularly for Black students who are nearly twice as likely to stay in four-year college if they receive aid. Considering that 48 percent of Black college-bound seniors in 1981 came from families with incomes under $12,000, as compared to only 10 percent of their white counterparts, the importance of financial aid for Black students cannot be overstated (College Board 1985).

Financial aid is one obstacle to college graduation; academic preparation is another. Retaining Black students in the educational pipeline is an important priority in increasing the pool of medical school applicants. The importance of early academic training and encouragement on later career choices becomes evident from the research of Berryman (1983), who reports:

> The scientific/mathematical pool from which quantitative Ph.D. graduates ultimately derive first appears in elementary school. It emerges strongly before the 9th grade and is essentially complete by the 12th. The pool appears to reach its maximum size prior to senior high school and subsequently declines in size through graduate school.

The same argument easily can be made for those who would choose a professional medical career. The kind and quality of early school preparation and retention are critical to later career choices.

The literature on minority enrollment in medical schools outlines a variety of strategies for increasing minority acceptance rates to minimizing the risks of dropping out prior to graduation. A variety of activities appear significant: tutorial programs, effective financial and academic support systems, Black faculty members and an institutional commitment to recruit and retain Black students. The evidence is clear that schools with such programs also the show the highest Black medical student enrollments and graduates. Since 1974, there has been a decline in programs to help students succeed (Shea and Fullilove 1985).

The experience of the Federal government during the decade of 1964 to 1974 provides a lesson applicable to this discussion: social policy can influence higher Black enrollments. The activities of the federal government to expand the numbers of physicians and the subsequent rise in enrollments and graduations argue that point. The decline in those numbers when this was no longer a federal priority adds further support. In addition, the proportionate decline in Black student enrollment in medical school at the same time as a lessened commitment to affirmative action lends further support and credence to this premise.

New York has begun to respond to these issues in a variety of ways:

- Convening an Assembly Committee on Higher Education and Black and Puerto Rican Caucus co-sponsored conference in 1981 on minority access to the professions.
- Publication of a study by the Health Planning Commission in 1982.
- Establishing a Special Advisory Commission on Minority Enrollment in Medical Schools in 1982.
- Legislation in 1985 creating health care professional opportunity scholarships to provide minority students with up to $10,000 in financial assistance, loan forgiveness programs and professional opportunity scholarships of up to $5,000 per year. The program was expanded in 1986 to 100 awards.
- STEP (Science and Technology Entry Program), a science and enrichment program in math and science for minority and disadvantaged high school students, was established in 1985. The program was initially funded at $500,000 and was increased in 1986.
- The State Commission on Graduate Medical Education provides incentives to New York medical schools to accept more minority students. It has been recommended that each of the medical schools in the State and its affiliated hospitals establish an affirmative action program to recruit underrepresented minorities for residency programs.

Such discussions and actions must continue and be calculated in terms of their effectiveness in addressing the identified problems in generating Black health manpower.

### Health Institutions: A Case Study of Harlem Hospital

What institutions will serve in Black communities? The critical need to preserve and improve already existing institutions is exemplified in the following discussion of Harlem Hospital, a municipal institution in New York City.

Harlem Hospital Center has achieved one hundred years of eminence as a beacon of hope for the sick and the poor of New York City, and as a national leader in the education of Black physicians and nurses.

However, new ways of organizing and financing health care, the changing role of hospitals as the major provider of ambulatory care and the keen competition with the private sector for secondary and tertiary services have jeopardized the very existence of Harlem Hospital Center. As the major American institution for post-graduate training of Black physicians, Harlem Hospital has made a monumental contribution to medical education and clinical research. This hospital is recognized internationally for the training of medical/surgical specialists from Third World countries, many of whom return to their homelands.

This hospital continues to provide high-quality medical care to the community and to the working poor who must pay for their own care and are rejected by the voluntary health agencies in New York City. It is the major health care facility in the Central Harlem catchment area. To Black youth nationally, it remains the ideal place to train for careers in medicine and the allied health professions. To better meet these needs, greater support from both state and local as well as other sources are essential for survival of the Harlem Hospital Center.

## Recommendations

The data and trends presented in this paper suggest a range of recommendations to respond to the disparities in health status between Black and white New Yorkers. With a goal of improving the health of Blacks of all ages residing in New York, we propose that the State implement the following:

- Expand Medicaid eligibility to 100 percent of the poverty level for families of all sizes. The program could then draw into an insured pool thousands of poor New Yorkers who presently have no health insurance coverage.
- Extend medical insurance, through Medicaid or some other form of social insurance, to the working poor.
- Increase Medicaid reimbursement fees to retain and to encourage the participation of private physicians and specialists in the program.
- Decrease Medicaid recipient reliance on hospital emergency room and outpatient department care, and on shared health facilities, by developing opportunities for preventive care and private physician services. Enrollment of Medicaid clients in health maintenance organizations or other forms of prepaid enrollment plans could be instrumental in helping to achieve the objective of case-managed, preventive care.
- Support and expand the School Health Demonstration Program (SHDP), including institutionalization of school-based comprehensive health services.
- Target public information campaigns on preventive health and timely medical treatment to inner-city, poor, Black communities of the State.
- Establish presumptive eligibility for prenatal care by providers of such care to poor, pregnant women.
- Develop universal access for infant health services.
- Locate short-term placements for hospitalized addicted infants who no longer require supervised medical care.

- Prohibit nursing homes from discriminating against a patient or applicant for care on the basis of the patient's source of payment for nursing home fees and charges.

- Increase the number of physicians, dentists and allied health personnel serving inner-city, socio-economically depressed areas of the State by providing incentives, including loan forgiveness programs, for establishing practices in these areas.

- Implement those recommendations proposed by State Task Forces that would facilitate increasing the number of Black physicians and specialists practicing in the State, including those proposals to strengthen the early academic preparation of Black students; disseminate information on health careers opportunities to Black students; review medical school admissions criteria; increase the pool of Black medical school applicants; and expand medical school recruitment, financial aid and retention of Black students.

- Develop and implement strategies to increase the number of Black nurses and other allied health professionals in the State, including opportunities for career mobility.

- Require medical schools to meet performance goals for minority enrollment and graduation in exchange for continued State financial support.

- Increase the representation of Blacks in health planning.

- Support institutions that have traditionally been responsive to the needs of the Black community, such as City University of New York Medical School, Sophie Davis School of Biomedical Education, with a substantial resource commitment that will enable them to continue and expand programs; and replicate the efforts of institutions such as SUNY at Buffalo where eighty-eight out of two hundred and thirty-five medical students are minorities (1987).

- State funds should be appropriated for the support of institutions, such as Harlem Hospital, to train physicians, nurses and other allied health professionals, thereby facilitating smoother entrance for Blacks into health careers.

- Support community-based comprehensive health centers and the effort to make preventive health care accessible to the medically indigent in the Black community. In addition, hospitals and community-based clinics that serve predominantly Black populations should be supported in developing, providing and expanding a full range of comprehensive health services.

- Support the New York State Department of Health initiatives for expansion of community-based comprehensive health centers, including management assistance, financial support and the development of additional sources of capital.

- Develop innovative approaches, such as use of home visitors, to motivate Black families to seek preventive care.
- Set priorities for State funding allocations by specific targeting by disease, program and ethnic group in greatest need.
- Ensure that health information is disseminated to the Black community and improve and expand outreach programs.
- Develop a partnership between local communities and government. The diffusion of information aimed at ethnic and culturally diverse populations is more likely to be successful if it is planned at the community level. Ethnic communities need funding and technical assistance to identify their own problems and develop their own culturally relevant methods of solving them.

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## II. THE DEVELOPMENT OF BLACK CHILDREN IN NEW YORK: SELECTED ISSUES IN MATERNAL, INFANT AND CHILD CARE

As stated in the 1987 "Message to the Legislature," the Governor has made a commitment to investing in New York's youth. The healthy development of children is a public policy issue. It is the responsibility of government to ensure equitable access to services and opportunities that will enable youth to become dignified, productive adults.

Ensuring access and availability of care is the responsibility of government at every level--federal, state and local. The federal government must provide the foundation for state efforts. A preponderance of evidence underscores the insidious relationship between poverty and ill-health. Since 1980 there has been an increase in the number of poor Blacks who do not receive Aid To Families with Dependent Children (AFDC), food stamps or participate in the Women, Infants, Children (WIC) Program. Maternal and Child Health Block Grants and Title X Family Planning monies have been substantially reduced by federal budget cuts. These developments have exacerbated the problems of reduced access to preventive services and to maternity care, infant and child health services.

There is a critical need to examine the companion issues of maternal and child health in New York State's Black population. Although there have been improvements in health and longevity, serious disparities continue to exist between Blacks and whites with regard to maternal and child health indicators:

- Late or no prenatal care
- Poor nutrition
- Prematurity
- Maternal and infant mortality
- Immunization status

At no other point in life are interventions which address the special needs of at-risk children more potentially successful than in infancy. The health-care system must provide adequate resources and access to maternity care, infant and child health services. There are additional factors which determine utilization of services. Studies have shown that the educational attainment of mothers, for example, is a critical factor in the survival of infants during the first year of life. There is a need to develop strategies and allocate resources to those Black communities with serious high school dropout problems and high rates of adult illiteracy.

The issue of access to maternity care, particularly prenatal care, is the most critical issue in maternal health. Financial, cultural and geographic factors determine access. In many poor Black communities services may be limited and/or of poor quality; there is a lack of targeted education and outreach. Other problems which affect utilization include the increase in the use of drugs and alcohol among pregnant Black women.

Birthweight, nutrition, physical and developmental problems (including AIDS), access to prenatal and infant health services are issues which affect the survival of Black infants in particular. For Black children in New York, immunization, the preventable causes of morbidity, the increased risks of infection in large group child-care settings and access to child-health services are the issues which warrant policy and programmatic emphasis to improve health status.

It is the appropriate role of government, at all levels, to ensure access and quality care and to reduce barriers. The Subcommittee on Health recognizes the importance of socio-economic improvement in relation to health status. Poverty, poor housing , low educational attainment and unemployment are powerful negative factors that combine to prohibit substantial gains in the health status of Black New Yorkers. The primary requirement for improving health status is the resource allocation for education, housing, nutrition and health services. The Subcommittee has focused its work on those specific health-related factors that require programmatic strengthening or policy responses on the state level to improve the health status of Blacks in New York.

## Maternal Health

Any relevant assessment of the health status of Blacks in the first phase of the life cycle must begin with a critical look at the mental and physical condition of Black mothers and their access to appropriate women's health-care services. Maternal health indicators, like those of infants and children in New York State, reflect serious racial disparities. In 1984 the maternal mortality rate for Black New Yorkers (3.6 per 10,000 live births) was more than two-and-a-half times that of whites (1.3 per 10,000 live births) (Randolph and Rivers 1985).

There are a number of maternal factors associated with a high risk of infant mortality. Age (17 years and under or 35 years and over) is one factor which adversely affects pregnancy outcomes. Early parenthood among Black teenage girls is a serious problem in New York and, increasingly, younger teens (under 15 years) are experiencing unintended pregnancies.

Education is another factor associated with the survival of Black infants. The educational attainment level of mothers influences the health status of families. In impoverished communities where the percentage of high school graduates is low, health status also tends to be poor. In New York State, 25.7 percent of Black families live below poverty. Low socio-economic status has major negative implications for access to health and other services.

Substance abuse is a problem which has a devastating effect on women and children. Of the 3,000 infants served through the Infant Health Assessment Program (IHAP) in New York City, 30 percent are with mothers who have shown evidence of being substance abusers.

More than half of Black pregnant women in New York receive late or no prenatal care. The greatest single cause of infant mortality is low birthweight--12.1 percent of Black infants are born weighing less than 2,500g. In 1984, only 44 percent of New York State Black women received early prenatal care, yet the relationship between early prenatal care and pregnancy outcome, optimal birthweight, in particular, has been well documented (Institute of Medicine 1985).

New York State's performance with regard to prenatal care, however, is poor. In 1983, New York ranked 44th out of 51 states with respect to the percent of women receiving early care; 36th out of 51 for white women receiving early care; 46th out of 51 for Black women; 47th out of a possible 50 for white teens; 46th out of a rankable 48 for non-white teens. New York ranked 48th out of 51 with regard to the percentage of women receiving late or no prenatal care; 47th out of a rankable 48 among non-white women; and 48th out of 51 with regard to white women (Rosenbaum 1986).

## Access To Maternity Care

In a policy paper prepared for the Bush Institute Child and Family Policy Conference, entitled "Financing Maternity Care," Rosenbaum and Hughes offered the following rationale for the recent concern among policymakers, advocates and public health professionals about the cost of and access to maternity care. The authors stated that this increasing attention stems from several factors:

- the concept that access to maternity care is basic to the notion of a fair and just society
- the value of effective maternity care in improving pregnancy outcomes
- the short-term and long-term cost-effectiveness of maternity care
- growing poverty among families with children and the increasing lack of insurance among such families
- the medical malpractice crisis which has increased the cost of maternity care and reduced the willingness of providers to be charitable
- changes in the health-care financing system which may adversely affect the availability and quality of maternity care
- the reliance on sophisticated technology (to reduce infant mortality) which is expensive as well as increases the risk of lifelong disability that confronts low birthweight infants
(Hughes and Rosenbaum 1986)

The Institute of Medicine's Committee to Study the Prevention of Low Birthweight concluded that the major barriers to early receipt of prenatal care fall into the following six categories:

- financial constraints such as inadequate insurance or lack of Medicaid funds to purchase care
- limited availability of maternity care providers, particularly providers willing to serve socially disadvantaged or high-risk pregnant women
- insufficient prenatal services in some sites routinely used by high-risk populations, such as community health centers, hospital outpatient clinics, and health departments
- experiences, attitudes, and beliefs among women that make them disinclined to seek prenatal care
- poor or absent transportation and child care services
- inadequate systems to recruit hard-to-reach women into care

The Institute of Medicine study cited financial barriers as a major obstacle to receipt of prenatal care. In New York State there are approximately 44,000 women, largely in the New York City area, who have limited or no access to prenatal care services (New York State Department of Health 1986). Although the following maternity care statistical analysis has not been compiled on a state level, nor is it available by race/ethnic group, it can be inferred that for low-income Blacks, and particularly Black immigrants in New York, financial constraints pose a major barrier to receipt of maternity care services.

Maternity care includes prenatal care, nutrition, genetic counseling, labor and delivery, interconceptional care, family planning and postpartum medical and hospital services. It is expensive, and the evidence overwhelmingly shows that many pregnant Black women, despite various sources of public and private coverage, do not have access to maternity services. As a result, they are unable to obtain adequate medical and related care. Program performance data for both AFDC and WIC are particularly disturbing. New York's AFDC payment level amounted to only 64 percent of the federal poverty level in 1985. Thousands of women have been left without either income or insurance because these poverty levels essentially determine Medicaid eligibility ( Rosenbaum 1986).

The following medical costs (based on data from the Insurance Association of America) reflect the expensive nature of maternity care nationally:

- $2,300 to $3,600 for an uncomplicated delivery
- $3,600 to $5,000 for a cesarean delivery
- $1,000 in clothing for mother and child
- uncalculated loss of income for illness during pregnancy
- costs associated with initial hospitalization of a low birthweight infant in an intensive care unit can range from several thousand dollars to as high as $134,000

Approximately 40 percent of all births in the United States are to women aged 18-24. In 1984, however, more than 25

> percent of women in these prime childbearing years had no private insurance or comprehensive public health coverage. (Gold and Kenney 1985)

The American College of Obstetricians and Gynecologists (ACOG) recommends 13 prenatal care visits during the course of an uncomplicated pregnancy. National data show that between 15 and 40 percent of all expectant mothers undergo ultrasound, and many women over the age of 35 seek amniocentesis. However, since genetic counseling services are not available to all women and many women do not seek care for pregnancy until 20 weeks into the pregnancy, many women with indications for amniocentesis e.g., advanced maternal age, sickle cell trait, etc. do not have amniocentesis. Approximately 20 percent of all pregnant women are at high risk of a poor pregnancy outcome. The average birth usually requires a hospital stay of three to four days if there are no complications, however, 56 percent of all pregnancies involve one or more complications. Twenty percent of all births are by cesarean section and 90 percent of these involve at least one complication (Gold and Kenney 1985).

## Women, Infants, Children Program (WIC)

Aside from prenatal care, favorable pregnancy outcomes for Black women are particularly dependent on factors that are potentially detrimental prior to conception, such as smoking, drug abuse and nutritional status. Black women--teenagers, older women and women who smoke--are more likely to experience problems in pregnancy outcome and are less likely to gain adequate weight during pregnancy.

Nationally, the WIC program (a special supplemental feeding program for women, infants and children) has contributed to lower rates of premature birth, better nutrition among mothers and infants, fewer stillbirths and better intellectual development of preschoolers. Even with the New York supplement to WIC, however, the food program reaches only 46 percent of all potential eligibles. The WIC program has been proven effective in increasing weight gain among low-income, pregnant women who are most likely to have diets increasing their risk of inadequate weight gain during pregnancy.

A national evaluation of the WIC program by the National Center for Health Statistics found that WIC has substantial effects on pregnant women, newborns, infants and preschoolers. Participation in WIC resulted in significant increases in early enrollment in prenatal care and participants had longer gestation periods. WIC resulted in increases in birthweight and infants born to WIC mothers had average head circumferences greater than infants born to non-WIC mothers, signifying brain growth.

In addition, both infants and preschoolers benefited from WIC by significantly increased intakes of iron and vitamin C. They were also more likely to have regular sources of health care and to be fully vaccinated. Finally, WIC families have diets with better nutrient quality than non-WIC families with comparable food expenditures. The results of the evaluation overwhelmingly support the need for an expanded WIC program.

## Access to Family Planning Services

Family planning care is a type of primary health care that emphasizes health promotion, particularly reproductive health care, maintenance and education. It serves as a point of entry into the health-care system for many women, and for poor women it is often the major or only source of care (Jones 1985).

Research indicates that the national reduction in infant mortality over the past 20 years is due in part to effective family planning, particularly for low-income women and teenagers. It has also been suggested that family planning increases the interval between births for many women.

A short interval between pregnancies is a risk factor for low birthweight and the practice of family planning reduces this risk (Institute of Medicine 1985).

The availability of abortion is the most important factor explaining declines in Black neonatal mortality. Therefore, the implications for access to contraceptives are clear. Nationally abortion accounts for 10 percent of the total observed decline. Induced abortion, like family planning, also increases the intervals between births and averts childbearing in high-risk women (What Factors Have Influenced U.S. Decline in Neonatal Mortality 1985).

For many Black women in New York, there is an unmet need for family planning. This is evident by the number of unintended pregnancies, as measured by the number of abortions among Black women, and the percentage of Black women at risk for unintended pregnancies who do not use contraception or obtain family planning services. Those at particularly high risk for low birthweight -- low-income women and teenagers--are most in need of subsidized family planning services (Institute of Medicine 1985).

Not only do family planning programs serve as a primary resource to help low-income women limit unintended fertility, they also serve as a primary resource for overall health care for these women. Family planning clinics serve as an important site for the early detection of potentially adverse health conditions through their diagnostic and health screening procedures (Jones 1985). In New York State family planning services are delivered through a broad range of service sites, including hospitals, health departments, clinics, community health centers, Planned Parenthood clinics and other agencies. The diversity of agency types in New York does facilitate choice among those women seeking care, however, only 34 percent of women in need are served by organized family planning programs in the

State. Only 17 percent of women in need are served by private physicians, thus it is clear that a low proportion of low-income women in New York are served (Jones 1985).

The State of New York contributes only 12 percent of the funding for family planning, however, both Medicaid and Social Services Block Grants are administered through the State Department of Social Services. The Department of Health Bureau of Family Planning administers the majority of grant-specific family planning dollars. As a result, family planning receives attention on the state level in New York as a health priority. Unfortunately, the fact remains that many Black women have no or limited access to family planning services (Jones 1985). Of the 354,000 women in New York who received family planning services in 1983, only 20.9 percent were Black (Alan Guttmacher Institute 1984).

## Infant Health

Infant mortality is a universally accepted measure for assessing the overall well-being of a population because it is an indication of general socio-economic and health conditions. An infant who lives through the first month of the neonatal period is influenced by a great many factors, including the physical condition and nutrition of the mother, congenital anomalies, the quality of prenatal care and the delivery environment.

The survival of the infant beyond the first 28 days of life (postneonatal period) is dependent on a complex set of interrelated factors. Environmental or socio-economic circumstances, such as nutrition, medical care, sanitary conditions and dangerous exposure to accidents, abuse, lead poisoning, etc., are all important in assuring infant survival (U.S. Commission on Civil Rights 1983). While it has been shown that these factors are commonly present in Black communities, the Subcommittee focused on the health factors which affect Black infant survival.

Infant mortality has consistently declined in the past decade for all racial groups, however, the gap remains wide between Blacks and other groups. New York State had a Black infant mortality rate of 17.4 per 1,000 live births in 1984, that is to say, for every 1,000 Black babies born in New York, more than 17 die. This rate is nearly twice that for white infants. Neonatal mortality for Blacks was 10.7 per 1,000 live births, nearly two-thirds higher than that of whites. Postneonatal mortality, which reflects the mortality rate of infants after the first month of life, was 5.2 per 1,000 live births among Blacks in 1985, compared to 2.6 per 1,000 live births among whites.

Approximately 80 percent of postneonatal mortality involves full-term, full-weight infants. Black infants born at full-term and optimal weight are still more than two times more likely to die during the postneonatal period than white infants. The racial differential in postneonatal mortality among full-term, full-weight infants is even greater than the Black/white differential for overall infant mortality. The postneonatal mortality rate for Black infants indicates a deterioration in the public health and preventive health systems, and in the ability of families to meet their infants' basic needs (Children's Defense Fund 1985). With appropriate and accessible health care, support for families and other interventions, many infant deaths can be averted.

Infant mortality is highly concentrated in certain areas of the State with the greatest problems in areas which are low-income and predominantly Black and Hispanic. Central Harlem has the highest Statewide infant mortality rate at 27.6 per 1,000 live births. A 1983 analysis of infant mortality rates in New York City showed that Black infants still have the highest mortality rate even when controlling for age and education of the mother, for public versus private hospitalization and method of payment (as proxies for socio-economic status), for low birthweight and for marital status (Blumenthal and Pakter 1984).

The relationship between early prenatal care and normal birthweight is well known. Yet, the same New York City analysis indicated that even when non-white women received early prenatal care their infant mortality rate was higher than that of whites (Blumenthal and Pakter 1984). More than 12 percent of Black infants are born weighing less than 2,500 grams. The previous discussion on maternal health highlighted the importance of receiving quality prenatal care to avoid low birthweight; however, the gap between white and Black newborns will not be closed simply by reducing the proportion of Black infants with low birthweight to the levels now experienced by whites. What will be necessary is an accompanying improvement in the survival rates of Black infants born at normal and optimal birth weights (What Factors 1985). Early and continuous health care for children saves lives and averts long-term health problems.

In a national study of the factors which have influenced the decline in neonatal mortality it was found that there are significant differentials in the patterns of influence for Blacks and whites. The availability of abortion is the most important factor explaining declines in Black neonatal mortality. Nationally, it accounts for 10 percent of the total observed decline. The availability of sophisticated neonatal care techniques is the second most important factor for Blacks followed by improved schooling among Black women of childbearing age (What Factors 1985).

In New York City the infant mortality rate associated with narcotic use increased from 42 per 1,000 live births in 1976 to 52 per 1,000 live births in 1983, the highest mortality for any single condition or complication of pregnancy. The incidence of Sudden Infant Death Syndrome is also higher among infants of drug abusers. Mortality associated with alcohol declined from 20 per 1,000 live births to 15 per 1,000 live births and mortality associated with tobacco addiction increased from 16 per 1,000 live births to 21 per 1,000 live births during this period. A comparison of infant mortality rates by race, for all substance abuse including tobacco, showed that the rates are higher for Blacks than whites (Blumenthal and Pakter 1984).

Over the past year a growing number of babies born to drug abusers remain in New York City hospitals. The children of "crack" users present a special problem. Many are low birthweight with accompanying problems. As yet, there has been no systematic study of the long-term effect of "crack" on infants or the risk to their physical and developmental progress. Although an infant's physical needs can be met in a hospital setting, it is not the optimal environment to supply the emotional support and stimulation needed for normal development of a child.

## Child Health

The New York State Department of Health offers a wide range of services. Improvement in the rates of immunization, infant mortality, childhood communicable diseases and access to health care through school health clinics, etc., provide clear evidence of the State's commitment to provide services to children. However, many children have health needs that go unmet. The concentration of health problems among children in certain neighborhoods is disturbing. These neighborhoods/areas are predominantly Black and Hispanic and low income. For youth, in these areas in particular, access and availability of basic health services including prevention, screening and treatment are crucial to proper growth and development.

There are a number of health problems that plague Black children in New York and that deserve immediate public health interventions. Lead poisoning and sickle cell anemia are longstanding problems for Black children.

Accidental death among children under 14 years is considerably higher for non-whites than for whites (17.8 compared to 12.4 per 100,000 in 1983). A National Health Interview Study conducted by the National Center for Health Statistics from 1979-81 revealed that 39.8 percent of Black children in the New York City area had not seen a dentist in the past year. While no reliable data is available for upstate youth, the figures are probably similar.

In addition, problems of poor nutrition -- obesity, iron deficiencies, the improper dietary habits of excess salt, fat and sugar intake and insufficient fiber -- and a low tendency to breastfeed among Black mothers, are continuing and well-recognized issues. Children who receive comprehensive pediatric care have been shown to have annual health care costs nearly 10 percent lower than children who do not receive such care (Children's Defense Fund 1985). In the area of child health the Subcommittee placed primary emphasis on immunization, nutrition, children at medical/social risk for physical/developmental problems, day care sanitation standards, and access to child health services.

## Immunization

Immunization is the most effective measure for prevention of infections and communicable diseases of childhood. Although considerable progress has been made on both state and national levels to vaccinate increasingly higher proportions of target populations, continued, expanded and improved outreach approaches are needed to maintain past successes and to avoid future illness and deaths from these diseases.

New York State has an excellent immunization record with regard to school age children -- fully 97 percent of all school age children have documented immunity against diphtheria, pertussis, tetanus, polio, measles, rubella and mumps -- largely as a result of mandatory immunization for school entry. Several years ago, however, a sizeable proportion of New York City children were not immunized, particularly Black children from the Caribbean. Furthermore, preschool children are not fully immunized. Although data on immunization by race is not available on the State level, nationally less than half of all poor and minority children under age four are fully vaccinated against the preventable infections of childhood (Hamburg 1985; New York State Department of Health Immunization Bureau 1986). Moreover, there is a critical need to emphasize the importance of immunizing children on time, as recommended by pediatric experts. Often the expense of vaccines precludes the receipt of preventive care.

## Children at Medical/Social Risk for Physical/Developmental Problems

In New York State many Black children between the ages 0-5 years are at risk of physical and developmental problems because of one or a combination of the following problems: low birthweight, mother's age less than 16, prematurity, sickle cell disease, major congenital anomalies, neonatal infections and maternal substance abuse. It is known that 12 percent of

Black infants are born weighing less than 2,500 grams in New York, however, unfortunately the State does not collect data by race on any of the other aforementioned indicators of risk.

The Infant Health Assessment Program (IHAP) identifies and monitors at-risk infants and children 0-5 years and provides linkages with appropriate services. At present there are twelve New York City hospitals that have IHAP, the majority of these are municipal hospitals. The remaining municipal hospitals are uncovered by IHAP and there are currently no monies available to extend the program. New York City data indicates that of the 3,000 infants who have been enrolled in IHAP, 30 percent are with mothers who have shown evidence of being substance abusers. Furthermore, the majority of children enrolled in the Pediatric AIDS Program of the AIDS Institute are Black or Hispanic. Most of these cases are in New York City. As of January 1987, 59 percent of these children are Black. Of the 142 non-transfusion associated cases, largely IV drug using mothers or mothers whose partners were IV drug users, 86 (61%) are Black.

Also related to the problem of drug abuse is the issue of "boarder babies." The problem of "boarder babies" is relatively unique to New York City. In 1986, on any given day, the average number of infants or children waiting in hospitals for placement in foster care was 167. The number has continued to increase in 1987. Approximately 75 percent of the children waiting in hospitals for foster homes are Black. These infants are at risk for mental and physical disability, resulting from the lack of nurturing under such circumstances. Many of these infants and children are in hospitals because they have been abandoned, their mothers are substance abusers or their parents were neglectful; some were born with AIDS.

In older children, lead poisoning, iron deficiency anemia and recurrent otitis media, which causes deafness, are the major contributors to physical and developmental problems.

## Day-Care Sanitation Standards

Since the early 1970s there has been a growing trend in day-care center use. Day-care centers have been especially beneficial to poor and minority women with limited access to private child care, however they are also known to be important in the spread of childhood infections. Poor hygienic practices in these settings -- lack of toilet training among the youngest children in the group, frequent handling of multiple children by care-givers, close contact among children, the tendency of young children to put hands and other objects in their mouths -- combine to set the stage for high rates of infection (Bartlett 1985). This is particularly true in unlicensed day-care settings which are often the most realistic options for women who work, but cannot afford private child care or to travel great distances to licensed day-care settings.

It is important that health departments and health-care providers recognize the special needs for the control of infectious disease in child-care settings. There are a number of approaches that can be utilized to effectively reduce the rate of infection among day-care groups of children. It seems obvious that hand-washing and good hygiene practices are essential, and studies suggest that lower infectious disease rates are found in child-care settings with small groups (Bartlett).

## New York State Maternal/Child Health Programs

The New York State Department of Health has consistently developed broad-based programs and initiatives to meet the needs of its residents. The Division of Family Health within the Office of Public Health provides the majority of maternal and child-health services. The following list of programs includes their intended level of funding, persons served and, more specifically, the number of Blacks served (1986).

### Women Infants Children Program (WIC)

Provides supplemental food and nutrition education; funded at $136,000,000; serves 74,806 Blacks (33 percent of the total persons served).

### Supplemental Nutrition Assistance Program (SNAP)

Provides supplemental food and nutrition education; funded at $25,700,000; serves 14,564 Blacks (33% of total persons served).

### Child Care Safety Seat Program

Loans safety seats to low-income families and provides education on proper use; funded at $375,941; serves and estimated 1,200 Blacks (20 percent of the total persons served).

### Genetics Psychosocial Services Program

Provides family support, educational, vocational, financial and psychosocial services to genetically affected children and to their families; funded at $155,000; serves an estimated 350 Blacks (50 percent of the total persons served).

### Primary and Preventive Services to Children -- Birth to Five

Reduces preventable causes of childhood morbidity and mortality through primary and preventive care by appropriate providers in community health settings; funded at $846,620; serves an estimated 6,000 Blacks (50 percent of the total persons served).

### School Health Demonstration Program

Provides Comprehensive School-Based Health Clinics; funded at $2,934,285; serves an estimated 39,600 Blacks (60 percent of the total persons served).

### Coordination of Care for Chronically Ill Children Demonstration

Coordinates services across medical, psychosocial, educational, vocational and financial needs on a demonstration basis at four sites; funded at $350,000; serves an estimated 100 Black children and their families (25 percent of the total persons served).

### Dental Rehabilitation Program

Provides orthodontic and rehabilitative dental services; serves 1,330 Blacks (10 percent of the total persons served).

### Preventive Dentistry for High-Risk and Underserved Children

Provides dental screenings, preventive dental services, health education and referral services; funded at $272,000; serves 6,000 Blacks (25 percent of the total persons served).

### Supplemental Flouride Program

Provides weekly flouride mouth rinses; funded at $88,000, serves 4,500 Blacks (5 percent of the total persons served).

### Low-Birthweight Prevention Program

Provides comprehensive prenatal services for women at risk for delivering low birthweight infants; funded at $1,823,947; serves 1,894 Blacks (49 percent of the total persons served).

New York City Maternity Infant Care Program

Provides comprehensive prenatal care to high-risk women in New York City; funded at $8,807,577; serves 7,298 Blacks (40% of the total persons served).

Prenatal Care Nutrition Program (PCNP)

Provides comprehensive prenatal services to women ineligible for Medicaid; funded at $17,500,000; serves 7,000 Blacks (50 percent of the total persons served).

Pediatric AIDS Program

Provides identification and follow-up services for at-risk infants and children 0-5 years for the purpose of linkage with appropriate services; funded at $1,100,000.

## Recommendations

### Maternal Health

A concerted State effort is required to ensure that Black women obtain the care needed for their own physical well-being and that of their infants and children. In the area of maternal health, the Subcommittee places primary emphasis on the promotion of early and consistent use of prenatal care by all pregnant women.

- The State should ensure universal access to prenatal care services and support and initiate the development of appropriate, accessible, culturally compatible services. In addition, the State should develop ongoing means of monitoring the efficacy of the regional perinatal networks.

- Reducing the rate of Black infant mortality and morbidity, prematurity and low birthweight will require expanded, targeted and non-traditional approaches to outreach to encourage mothers to seek early prenatal care: a targeted public education campaign for Black women to encourage breastfeeding; a strengthening of parent and nutrition education components of the WIC program and expanded availability/ accessibility to reach 75 to 95 percent of potential eligibles.

- The Subcommittee fully supports the recommendations of the Department of Health and Human Services report, 1990 Objectives for the Nation, to develop, implement and evaluate health education (through work sites, schools, mass media and elsewhere) on the avoidable risks to maternal and fetal health during pregnancy (i.e., poor nutrition, use of alcohol, cigarettes and drugs and the importance of breastfeeding).

## Infant Health

In the area of infant health, the Subcommittee focused on the newborn through the first year of life and placed primary emphasis on preventive services for "boarder babies," infants who stay in a hospital beyond the time that they require medical care.

- The State should develop means for short-term placement of addicted infants, perhaps using retired nurses, older couples or singles who are capable of providing a quality environment in alternative foster care arrangements. The State should also provide adequate supports which would increase the willingness and ability of Black families to provide foster care. In addition, the State should make available preventive mental health services to avert retardation.
- The State should address the needs of infants at medical and/or social risk for physical and/or developmental problems (i.e., infants with AIDS or genetic problems, etc.) by increasing the funding available for the Infant Health Assessment Program, (IHAP), which currently meets only 60% of need.
- Universal access for infant health care services should be ensured, including expanding access to the WIC program and immunization services. This will also require non-traditional approaches to outreach.

## Child Health

In the area of child health the Subcommittee identified immunization, nutrition and day-care sanitation as priority issues. Immunization is the most effective prevention for the common infections of childhood and their often disabling complications. Among poor and minority children under age four, national data indicate that less than half are fully vaccinated against preventable infections.

- The State should ensure immunization of toddlers in and out of day-care programs for Hib, MMR, polio and DPT. The State should also ensure increased availability of free vaccines to primary health-care providers in high risk areas.

- The State should ensure improved sanitation standards and good hygiene practices in day-care programs. Small group child care should be encouraged.

- The State should provide adequate health education for day care and WIC program staff and families on nutritional and genetic issues particularly obesity, iron deficiency and sickle cell anemia.

- The State should increase access to dental health services for Black children who do not receive regular dental care.

- The State should expand nutrition education efforts and food supplementation as needed, to address obesity and iron deficiency in Black children.

- The State should expand the current State funded school demonstration project models into permanent programs in elementary schools, where low-cost, or no cost, primary health services are not readily available. These programs should be institutionalized so that they are available in all high-need communities across the State. This may require changes in both health and education statutes, and will require additional State funding. In addition, the State should implement health demonstration projects in day-care settings similar to those in schools.

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## III. RISK-TAKING AND RESILIENCE:TROUBLED YOUTH IN TRANSITION
## THE HEALTH IMPLICATIONS FOR BLACK ADOLESCENTS

It is true that alienation, anomie and lack of direction characterize much of the social fabric of our time, and that such evidence can be seen in all social and economic classes. Yet children who are born in poverty, reared in disease, ill-housed and poorly fed are impelled to move from unwanted birth and malnourished infancy to poorly educated childhood, from unskilled, unguided adolescence, into unemployment, non-productive adulthood. These are the children deprived, at their very birth, of years which they will never live, malnourished because of prenatal care which their mothers did not receive, unprepared for an educational system which has not yet learned to reach them or teach them. They grow up in our inner cities, in those communities in which the struggle of life is carried on with unpredictable, uneven success, often lacking inner strengths to cope successfully with a deprived environment or the wisdom to understand its real causes.

Dr. June Jackson Christmas

A recent study conducted by the National Research Council (1986) on adolescent sexuality, pregnancy and childbearing emphasized the importance of understanding teenage sexual and fertility behavior and decision-making within the changing societal context of adolescence. Changes in society -- in patterns of marriage, family-life structure, economic stability and poverty status, women's roles and sexual behavior, technological advancement and youth culture--combine to impact on youth development. There are differences in the ways that these factors affect teenagers of different racial groups. For example, the impact of women entering the workforce during the 1970s was not as great among Blacks given the fact that Black women have always worked outside the home and, more often than not, have had to assume responsibility for the economic support of their families. Nevertheless, the societal context within which adolescents develop provides the basis for understanding their sexual, fertility-related and risk-taking behavior.

It is clear that changes in family structure play a major role in the social context of Black adolescent development. As a consequence of the rising rate of births outside of marriage, separation or divorce, increasing numbers of Black teenagers live in single-parent families. In the Black community this pattern began in the mid-1940s and increased rapidly in the 1960s. Childbearing outside of marriage, particularly among teens, has become the primary cause of single parenthood among Blacks. National data indicate that 48 percent of Black men are fathers by age 24-25 compared to 28 percent of whites, and less than one-fifth of these young Black fathers live with their children. Furthermore, at every age proportionately fewer Black women and men are married than white, and young Black fathers, regardless of whether they are living with their children, are significantly less likely than white fathers to marry the mothers (National Research Council 1986).

Economic stability in families has a profound impact on adolescent development. Unemployment is significantly higher among Blacks than among whites in New York State, especially among mothers who are single parents. Black families headed by women are more likely to be poor than white families headed by women. The median income of Black families with children in New York is $11,752; among Black female-headed families with children median income is $6,544. In contrast, among married couple Black families with children, median family income is $20,213; among such white families median income is $23,891.

Black male unemployment is 13.1 percent compared to 6 percent for white males; among Black teen males 16-19 years, unemployment is 40 percent compared to nearly 18 percent for white male teens. High unemployment rates among young Black men pose a serious deterrent to the establishment of economically viable and stable marriages.

More than 36 percent of Black children in New York State live in poverty. White children in two-parent families benefit from higher median family incomes largely because the average earnings of white husbands are higher. Among Black children living in single-parent families the proportion in poverty is even greater. Only 41.5 percent of Black teens in New York State live in two-parent homes. Nearly 31 percent of all Black families with children in the State are headed by women. Sixty-eight percent of poor Black families are female-headed, single-parent families.

Apathy, alienation and hopelessness have become prevalent attitudes among many poor black youth as a result of the harsh social pressures they encounter. For many Black adolescents living in depressed communities, the institutions which have traditionally offered support for poor families are weak or non-existent. Weak linkages between these youth and the education and health systems exacerbate the isolation felt by those who increasingly live on the fringes of the "mainstream." This growing alienation from society manifests itself in a number of serious social problems, ranging from premature childbearing and "dropping out" of school to juvenile delinquency and drug abuse.

It is against this background that the Health Subcommittee identified the following issues as critical for the Black adolescent in New York: pregnancy and childbearing, homicide, suicide and substance abuse. For many Black youth in New York the normal stresses and tasks of adolescence are made more difficult by the combined influences of unemployment, a degrading public assistance system, a failing educational system and inadequate access to both preventive and curative health and mental health services.

There are four major tasks which adolescents confront during this period of transition to adult life: (1) developing a sense of psychosexual identity; (2) resolving the conflicts between dependence and independence; (3) development of a system of values, and finally; (4) choosing a vocation ( Christmas 1976). Teenage pregnancy and parenting, substance abuse and drug use, stress-related mental illness and interpersonal violence, combine to pose the most serious challenges to positive youth development. Health is a critical component of this process.

## Adolescent Pregnancy and Parenting

In the last 10 years, teenage parenthood has become generally acknowledged as a "problem." In 1984, 31 percent of all out-of-wedlock births among Black women were to adolescents. The rates among Blacks are significantly higher than among whites. There is undoubtedly a relationship between poverty factors and early childbearing. Teenage pregnancy on the other hand, is not a phenomenon unique to poor youth. Indeed, while birth rates among teens have declined in recent years, the rates of pregnancy and of sexual activity have continued to climb, particularly among younger teens, for Black and white youth alike.

The physiological, social and economic conditions associated with teenage childbearing have adverse consequences for adolescent mothers and their children. For the Black school-age mother and her child, in particular, the consequences are generally more intractable. The differentials between Blacks and other races with regard to pregnancy, childbearing and family income are widening. This gap is proof of the effects of poverty, uncertainty and lack of opportunities for Black youth. The Children's Defense Fund, a non-profit research and advocacy group based in Washington, D.C., compared national statistics for Black and white youth on high school completion, college enrollment and unemployment rates of 16 - 24 year olds not enrolled in school, by highest level of education completed. They found that to an alarming degree, Black youth lack both the skills and the opportunities to become self-sufficient adults. Poor schooling and resulting poor employment potential are the reasons that many Black teens are not motivated to delay parenthood (Edelman and Pittman, 1986).

Teenage childbearing cuts across many issues confronting the Advisory Committee for Black Affairs, including education, economic development, family stability, health care, human services and poverty. A combination of interrelated interventions will therefore be required to ameliorate this problem. Despite its complexity, and given what is already known, the State can reverse the trend of premature parenthood. The following review of the research provides some clues.

A recent Alan Guttmacher Institute (AGI) Study of Teenage Pregnancy in Developed Countries identified some factors at the national level that help to explain the pregnancy differentials among countries that have similar levels of adolescent sexual activity. Among them are the distribution of income, societal openness about sex and accessibility to contraceptives (Alan Guttmacher Institute 1986).

An interstate analysis of adolescent pregnancy among girls 15-19 years, also conducted by the AGI, found that New York State ranks 32nd in the United States for its rate of adolescent pregnancy. However, when the rates are disaggregated by race, New York ranked 5th (out of 22 states for which pregnancy data by race was available) for Black adolescent pregnancy (preceded by California, Minnesota, Nevada and New Jersey, respectively, from highest to lowest). New York ranked 33rd (out of 34 states for which racial data was available) for its Black adolescent birthrate. In contrast, New York ranked 2nd (out of 22 states) for its Black adolescent abortion rate (Alan Guttmacher Institute 1986).

Results from AGI's analysis of demographic, social and political factors support the hypothesis that communities with greater social and economic problems provide environments in which more teenagers are likely to become pregnant, to have abortions and to experience early motherhood (Alan Guttmacher Institute 1986). In 1984, 6.5 percent of all live births among non-Hispanic whites in New York State occurred to adolescents, compared to nearly 20 percent among non-Hispanic Blacks. That is to say, one in every five Black babies had a teenage mother. As is indicated in table 1, the majority of births to Black teenagers (73 percent) occur in New York City. Black teens account for 16.1 percent of the adolescent population 16-19 years in New York State and contribute 36 percent of all teen births.

The New York State Council on Children and Families reports that in 1980, the only year for which pregnancy rates by race are computed, non-white teenage pregnancy rates in New York State were two-and-a-half times the level of white rates; 150 pregnancies per 1,000 non-white females aged 15-19 compared with 60 pregnancies per 1,000 white females of the same age group. While the non-white rates were higher, there were more pregnancies among white teenage girls than non-white. In 1984, there were 36,496 pregnancies among white adolescents and 22,957 pregnancies among Black adolescents (See table 1).

Current research indicates that adolescent girls are increasingly trying to avoid pregnancy through the use of contraceptives, however, fewer adolescents use medically prescribed methods of contraception (pill, IUD) and more use less effective non-medical methods (condom, withdrawal, rhythm). Black female teens use contraception less often than their white counterparts, however, they use more effective methods (National Research Council 1986).

## TABLE 1

## Adolescent Pregnancies[a] By Ethnicity
## New York State, New York City, Rest of State: 1984

| | White | Black | Other | Total |
|---|---|---|---|---|
| | | **New York State** | | |
| Pregnancies | 36,496 | 22,957 | 377 | 60,709 |
| Births | 15,525 | 10,226 | 251 | 26,187 |
| Induced Abortions | 20,190 | 12,369 | 121 | 33,275 |
| Spontaneous Fetal Death | 781 | 362 | 5 | 1,247 |
| Births <2500 Grams[b] | 1,288 | 1,315 | 29 | 2,651 |
| | | **New York City** | | |
| Pregnancies | 14,058 | 16,830 | 139 | 31,427 |
| Births | 5,980 | 7,178 | 81 | 13,324 |
| Induced Abortions | 7,911 | 9,465 | 56 | 17,709 |
| Spontaneous Fetal Death | 167 | 187 | 2 | 394 |
| Births <2500 Grams[b] | 574 | 906 | 12 | 1,500 |
| | | **Rest of the State** | | |
| Pregnancies | 22,438 | 6,127 | 238 | 29,282 |
| Births | 9,545 | 3,048 | 170 | 12,863 |
| Induced Abortions | 12,279 | 2,904 | 65 | 15,566 |
| Spontaneous Fetal Death | 614 | 175 | 3 | 853 |
| Births <2500 Grams[b] | 714 | 409 | 17 | 1,151 |

**Source:** New York State Department of Biostatistics, 1984, Unpublished Data.

**Complied by:** New York State Council on Children and Families, Bureau of Research and Information Services, July 1986.

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[a] Adolescents under 20 years of age.

[b] Total includes births in which ethnicity was not known.

As table 2 indicates, 38 percent (22,709) of all teenage pregnancies in 1984 were to Black teenagers and 60 percent (35,858) were to white teens. Of all Black teens, 54 percent (12,369) terminated their pregnancies in abortion and 45 percent (10,226) carried their pregnancies to term.

### TABLE 2

### ADOLESCENT PREGNANCY NEW YORK STATE - 1984

| | TOTAL | WHITE | | | BLACK | | |
|---|---|---|---|---|---|---|---|
| | ALL TEENS | TOTAL | 10-14 | 15-19 | TOTAL | 10-14 | 15-19 |
| PREGNANCIES (SFD >20 WEEKS GESTATION) | | | | | | | |
| # | 59,735 | 35,858 | 687 | 35,171 | 22,709 | 1,069 | 21,640 |
| % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| BIRTHS | | | | | | | |
| # | 26,187 | 15,525 | 216 | 15,309 | 10,226 | 302 | 9,924 |
| % | 43.8 | 43.3 | 31.4 | 43.5 | 45.0 | 28.3 | 45.9 |
| INDUCED ABORTIONS | | | | | | | |
| # | 33,275 | 20,190 | 470 | 19,720 | 12,369 | 764 | 11,605 |
| % | 55.7 | 56.3 | 68.4 | 56.1 | 54.5 | 71.5 | 53.6 |
| SPONTANEOUS FETAL DEATHS (>20 WEEKS GESTATION) | | | | | | | |
| # | 273 | 143 | 1 | 142 | 114 | 3 | 111 |
| % | 0.5 | 0.4 | 0.1 | 0.4 | 0.5 | 0.3 | 0.5 |
| OUT-OF-WEDLOCK BIRTHS | | | | | | | |
| # | 19,095 | 9,418 | 203 | 9,215 | 9,376 | 299 | 9,077 |
| % | 72.9 | 60.7 | 94.0 | 60.2 | 91.7 | 99.0 | 91.5 |
| LATE OR NO PRENATAL CARE | | | | | | | |
| # | 5,651 | 2,839 | 80 | 2,759 | 2,728 | 115 | 2,613 |
| % | 21.6 | 18.3 | 37.0 | 18.0 | 26.7 | 38.1 | 26.3 |
| LOW BIRTHWEIGHT <2500 G | | | | | | | |
| # | 2,651 | 1,288 | 30 | 1,258 | 1,315 | 52 | 1,263 |
| % | 10.1 | 8.3 | 13.9 | 8.2 | 12.8 | 17.2 | 12.7 |

In 1982, 33 percent of all Black pregnant teenagers had a history of one or more prior pregnancies. In 1984, 20 percent of non-white teens who gave birth had a history of at least one prior birth. National statistics indicate that younger adolescent mothers, 15-17 years, have 46 percent more births than later childbearers and that 20 percent of teens who give birth are pregnant again within a year; 50 percent within two years (Alan Guttmacher Institute).

Of all births to Black teen mothers in 1984 nearly 92 percent (9,376) were out-of-wedlock. This represents a tremendous increase since 1972 when approximately 66 percent of all births to non-white adolescents occurred among unmarried teenagers. Raising children alone for a young mother would be difficult enough, however, over 60 percent of all female-headed households with children under the age of six currently live in poverty. In 1984, 31 percent of all out-of-wedlock births among Black women were to adolescents.

The magnitude of teenage pregnancy in New York is alarming in and of itself, however, even more disturbing are the negative consequences of adolescent childbearing. Limited access to and poor utilization of basic health services often lead to poor health outcomes for the infants of young mothers, as well as for the mothers themselves. Of all births to Black teen mothers in 1984 in New York, 12.8 percent were low birthweight, among younger Black teens 10-14 years, the proportion was 17.2 percent. Black teens contribute nearly 20 percent of all births to Black women in New York State; they also contribute nearly 23 percent of all low birthweight babies in New York State. Low birthweight is directly associated with lack of prenatal care. Table 2 shows that in 1984, 26.7 percent of Black teen mothers received late or no prenatal care. Among white teen mothers 18.3 percent received late or no prenatal care.

National statistics indicate that teen mothers are more likely to develop anemia and experience complications at birth. New York State hospital discharge data for 1982 show that 6,132 girls (15-19 years), the majority of whom were Black, were treated for obstetric diseases occurring before or after delivery (Randolph and Rivers 1985). The infants of teenage mothers face even greater health risks, including low birthweight and physical disability. The infant mortality rate associated with teenage childbearing in New York City, for example, is 27.4 per 1,000 live births. Beyond the numerous health problems that these children face are also the risks of social, emotional and cognitive deficits.

The younger the adolescent, the more likely are the chances that a pregnancy will be terminated by an abortion or end up as an out-of-wedlock birth. While broad attention must be given to the problems associated with early parenthood, pregnancies among girls under age 18 are of the utmost concern. National data indicate that in 1979, Black unmarried girls 15-17 years were one-and-a-half times likely to be sexually active as unmarried white girls 14-16 years. Births to teens have decreased significantly since 1970, except for those births to girls under 15 years (Black Adolescent Pregnancy 1986).

There is a synergistic relationship between early childbearing and poverty. Upwards of 60 percent of the 1983 Aid to Families with Dependent Children (AFDC) caseload in New York State was comprised of mothers who were teenagers when they gave birth to their first child. Furthermore, in the South Bronx, Central Brooklyn, East and Central Harlem -- three major poverty areas in New York City defined as health districts having the highest proportion of Medicaid funded deliveries-- teen births represented 23 percent of all births in 1984. Thirty-one percent of all births occurred in these areas and 51 percent of all births to teenage mothers in New York City (NYC Department of Health 1984). The population living in these districts is predominantly Black and Hispanic. Early childbearing is associated with significantly longer periods on public assistance. Research indicates that a non-white high school dropout who starts receiving welfare benefits as a single mother, will average approximately 10 years in her duration of AFDC dependency (Bane and Ellwood 1983).

Any analysis of the statistics presented in tables 1 and 2 must consider the socio-cultural context of extended families and female headship which is common among Black families. According to the 1980 New York State Census, 82 percent of white teens under 18 years lived with two parents compared to 41.5 percent of Black teens. Furthermore, reliance on financial support from adolescent fathers is not common among Black teenage mothers. Given the fact that the Black male teenager has an unemployment rate of nearly 40 percent in New York State, many young Black women never marry, forming their own households in poverty (Bane and Ellwood 1983).

The lack of motivation among Black teens to avoid pregnancy and parenthood is a critical issue both nationally and in New York. National labor force statistics show that even college degrees fail to guarantee economic security for Black youth. Black college graduates have about the same likelihood of being unemployed as white high school dropouts (Bane and Ellwood 1983). A study of early subsequent pregnancy among economically disadvantaged teen mothers found that from the perspective of this group of already pregnant or parenting teens, the "opportunity costs" (i.e., the foregone experiences and income) of a subsequent birth may be negligible. Even with a high school diploma, high-paying jobs for women without advanced training are almost non-existent (Polit and Kahn 1985).

Related to this lack of motivation to delay early childbearing is the common perception that parenthood precedes dropping out of school. Indeed, a number of recent studies provide evidence that many Black teen mothers

(14 percent) drop out of school some time before they become pregnant (Morrison 1982). Another study showed that among dropouts, pregnancy occurred to 49 percent of Black respondents after dropping out (Tanfer 1983).

Thus, it is clear that a broad range of interventions are required to both prevent pregnancy among Black adolescents as well as to improve the consequences of early parenthood. The latter requires more concentrated support, including educational opportunities, health and social services, child care, parenting training and job training.

Programs to prevent teenage pregnancy are of three general types and are designed for (1) knowledge improvement and/or influencing attitudes (2) family planning and access to contraception and (3) life option enhancement (National Research Council 1986).

Programs falling under the first category include sex education and family life education courses, assertiveness and decision-making training, family communication skills development, teenage theater projects and media approaches (National Research Council 1986).

Programs falling under the second category are largely family planning services. Black teenagers are more likely to rely on a clinic for their first source of prescription contraception than to visit a private physician. In contrast, white teens rely almost equally on both sources. Therefore, access to contraceptives through family planning clinics or school-based health clinics is particularly important for Black teens (National Research Council 1986).

Programs that enhance life options include life planning skills, innovative role model and mentoring, school performance improvement, youth employment training and comprehensive community-based prevention efforts (National Research Council 1986). The educational system must provide both skills and opportunities to Black youth given the relationship between poor school achievement and dropping out of school, followed by pregnancy and/or parenthood. The resulting poor employment potential evidenced by the high unemployment rate among Black teenagers makes obvious the particular appropriateness of the "life options" approach for Black teens.

Family planning programs are the only proven-effective intervention to improve contraceptive use and reduce the chances of teenagers having an unplanned pregnancy and out-of-wedlock birth. The availability of abortion is associated with a greater probability that a pregnant teen will have an abortion rather than an out-of-wedlock birth. Once a teen is sexually active, access to contraception is key to pregnancy prevention. The type of contraceptive method used and user satisfaction are very important.

A national analysis of the cost and benefits of government expenditures for family planning clinic programs found that for every $1.00 spent on family planning services $2.00 were saved in the first year in health and welfare costs; for teenagers the savings were $3.00 for every dollar spent (Chamie and Henshaw 1981). In a more recent study, the 1985 cost for a first birth to an unmarried teenager was estimated to be $13,902 (National Research Council 1986). The same analysis projects that an adolescent pregnancy intervention generates positive savings even if it only postpones a pregnancy for a year. The implication of this analysis is that programs/interventions will have the greatest results in terms of cost-effectiveness, if they are aimed at helping teens delay childbearing until they are at least 18 years old and have completed high school (National Research Council 1986).

New York State's commitment to prevention of teenage pregnancy and the provision of services to pregnant and parenting teens is evidenced by the numerous programs and services listed in Appendix A. The Governor's Teen

Pregnancy Initiative makes available $5 million for primary prevention demonstration projects, community services projects, outreach, training and public awareness.

There is a critical need to develop a comprehensive service system and to target resources to those areas in the State that have clearly demonstrated need. New York State should provide more culturally relevant and targeted services for youth that are easily accessible, with greater focus on the Black community. Prevention of pregnancies among Black girls under age 18 must be both policy and programmatic priorities for the State of New York. The Subcommittee focused its recommendations primarily on those programs for pregnant and parenting adolescents that provide a range of health and social services and coping skills. An all-out effort must take place if we are to shape a different future for these youngsters and ultimately for our State.

## Homicide

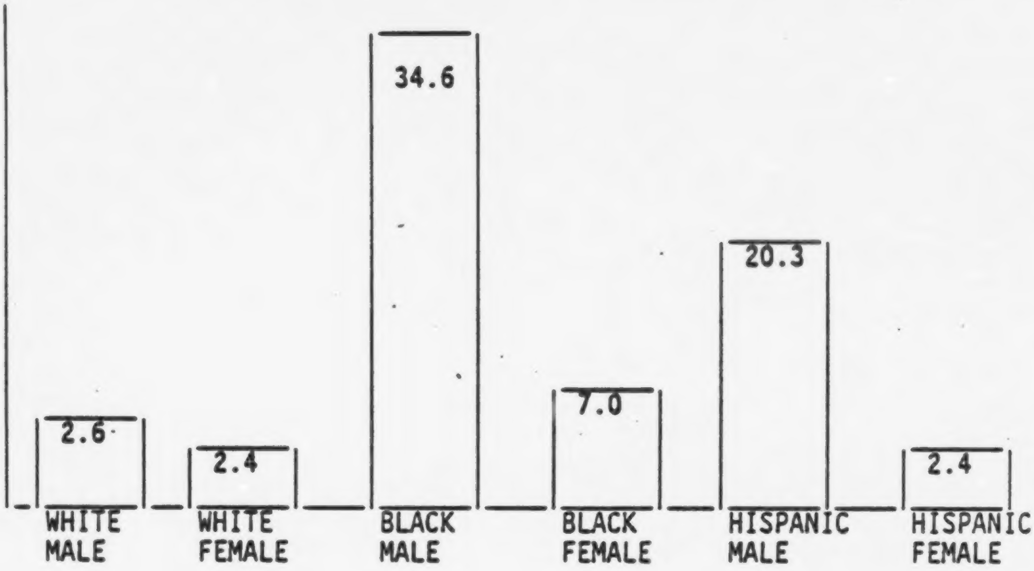
According to the Federal Task Force Report on Black and Minority Health, homicide is the leading cause of death for Black males of ages 15-44. The 1981 homicide rate for Black males, ages 15-24, was five times higher than that of their white counterparts. Over 50 percent of homicide victims are killed by persons known to them and most homicides committed against Blacks are committed by other Blacks. Nationally, Blacks accounted for 43 percent of homicide victims although they represented only 11.5 percent of the population in 1983.

The Federal Task Force on Black and Minority Health identified four principal factors that relate directly to the high incidence of homicide. These include psychological, environmental, physiological and lifestyle factors. The U.S. Department of Justice reports that Black males have a 1-in-21 lifetime chance of becoming a homicide victim. In stark contrast, white males is 1 in 131 lifetime chance of being murdered. While it would appear that suicide is the ultimate expression of alienation for Blacks, both nationally and locally, homicide is a public health problem for which, in the Black community, its statistical significance begins in the adolescent years.

Data in Figure 1 and table 3, provided by the New York State Department of Health (NYSDOH), illustrate the alarming homicide rates for Black youth. Homicide rates are four times higher for Black teens 15-19 years than for white (40.9 per 100,000 compared to 9.4 per 100,000 ). The rates are even more startling when disaggregated by sex. In 1984, Black males 10-19 years were murdered at a rate thirteen times higher than that of white males (34.6 per 100,000 compared to 2.6 per 100,000 for whites). Indeed, of the 157 deaths among Black boys 13-19 years in 1984, more than half (52 percent) were a result of murder. For the same white cohort only 5 percent of all deaths were a result of murder. Among Black teenage girls, 13-19 years, 25 percent of all deaths were a result of murder compared to 9 percent for their white counterparts (NYS Department of Health 1986).

**FIGURE 1**

**New York State Adolescent Resident Homicide Deaths**
**Age, Sex, Race Specific Rates* Per 100,000 Population**



* Rates were computed by dividing 1984 deaths by 1980 Census populations

## TABLE 3
## Leading Causes of Death
## By Age, Race and Sex
## New York State Residents

1984

| Male | Percent | Female | Percent |
|---|---|---|---|
| Age | Percent | | Percent |
| 13 - 19 | | | |
| | WHITES | | |
| Total Deaths | 508 | Total Deaths | 226 |
| Motor Vehicle Accidents | 40 % | Motor Vehicle Accidents | 32 % |
| Non-M.V. Accidents | 14 % | Homicide | 9 % |
| Suicide | 7 % | Suicide | 8 % |
| Homicide | 5 % | Non-M.V Accidents | 8 % |
| | BLACKS | | |
| Total Deaths | 157 | Total Deaths | 69 |
| Homicide | 52 % | Homicide | 25 % |
| Motor Vehicle Accidents | 8 % | Cancer | 9 % |
| Non-M.V. Accidents | 8 % | Motor Vehicle Accidents | 7 %. |
| Cancer | 4 % | Chronic Pulmonary Disease | 7 % |
| Heart Disease | 4 % | | |
| | HISPANICS | | |
| Total Deaths | 114 | Total Deaths | 35 |
| Homicide | 41 % | Cancer | 29% |
| Non-M.V Accidents | 12 % | | |
| Cancer | 9 % | | |

Source: New York State Department of Health, Bureau of Biostatistics, 1984.

Homicide is a measurable form of interpersonal violence as opposed to non-fatal violence, which is less reliably measured. According to Deborah Prothrow-Stith of Boston University, however, non-fatal violence occurs at significantly higher rates than homicide and young Blacks are disproportionately represented for both (Federal Task Force Report on Minority Health 1985). Each case of homicide of a child represents a death that should never have occurred. The high incidence of homicide among Black adolescents reflects inadequacies in their socio-economic circumstances, health and mental health services and other social support systems, which together help to promote survival and emotional well-being (Miller et al.1986).

While the traditional public health model has been applied to unintentional injuries only, increasingly homicide is being viewed as a public health problem. The Department of Health and Human Services has mandated the reduction of the rate of interpersonal violence and of Black male homicide by 1990, as a priority objective.

In an analysis of interdisciplinary interventions applicable to the prevention of interpersonal violence and homicide in Black youth, Prothrow-Stith emphasized that designing violence prevention strategies that are effective with urban Black adolescents of lower socio-economic status requires an understanding of adolescence, of issues of race and poverty. While the importance of understanding adolescent development is obvious, the normal and appropriate anger that results from racism is often ignored. Yet, it is contact with racism resulting in anger that appears to contribute to the overrepresentation of Black youth in interpersonal violence. Those factors which teach and reinforce violent behavior, those which are characteristic of poverty, are more prevalent in urban Black communities. In order to be effective, violence prevention strategies must have a realistic cultural context within which the violence, racism and classism that many Black teenagers experience is acknowledged (Prothrow-Stith 1985).

Preventing homicides will require the implementation of strategies involving health professionals, educators, social workers and community organizations. In all four categories, the specific involvement of persons or groups experienced and comfortable in working with youth is imperative. Coordination and collaboration of systems including health, education, social support and law enforcement are prerequisites for prevention efforts.

For the Black teenager, family violence, childhood aggression, school violence, adolescent violence and drug abuse are important focal points for efforts toward prevention of homicide. Such prevention strategies are particularly needed in low-income, inner-city communities characterized by high rates of violence, family disorganization, unemployment and school dropouts (Federal Task Force Report on Black and Minority Health 1986). A description of several exemplary violence prevention programs is provided in appendix B.

## Suicide

Suicide continues to be a leading cause of death among white adolescents accounting for 13 percent and 8 percent of deaths, respectively, among males and females 13-19 years. In contrast, suicide is not one of the five leading causes of death among Blacks in the same age cohort. However, between ages 18-24 years the incidence of deaths from suicide rises for Blacks. Suicide among Black males 20-29 years accounts for 6 percent of all mortality for Black men. Nationally, the suicide rates for all males 15-24 years increased 50 percent between 1970 and 1980.

Children, youth and young adults who are at increased risk of committing suicide include those with a history of serious psychiatric disorders, drug and alcohol abuse, depression, a sense of failure or humiliation. Indeed, drug and alcohol abuse may be disguised attempts at suicide which result in drunk driving, accidents and overdoses. Previous suicide attempts, suicide by another member of the family and availability of the means of taking one's life also increase the risk (Miller et al.,1986).

The statistical data available on suicide among Black youth does imply the need for policy and programmatic initiatives, with special emphasis on prevention beginning in the early and pre-adolescent years. Four potentially effective initiatives are: (1) intervention programs aimed at reducing socio-economic and emotional stress- causing conditions, (2) improved methods of detection and treatment of depression, (3) counseling and support programs for at-risk youth and (4) interventions with the goal of reducing access to suicide methods (Miller et al., 1986).

## Substance Abuse

Drugs, alcohol and tobacco use are serious problems among Black teenagers. The rate of increase for new smokers is greatest among Black adolescent women. While most teenagers probably believe that smoking is hazardous to their health, for adolescents in general, the long-term negative consequences of smoking seem very far away.

In 1983, the New York State Division of Substance Abuse Services (DSAS) conducted a statewide survey of substance abuse among high school students.

The study found that a similar proportion of white, Black and Hispanic students have been involved in substance use in the State's secondary school population. Information regarding drug and alcohol use among Black students in grades 7 through 12 was available through DSAS. Some highlights from the findings for Black students are the following:

- Black students (45 percent) had used one or more illicit substances and/or used psychoactive prescription drugs non-medically in the six months prior to the 1983 survey.
- Black students (19 percent) are considered to be regular or heavy substance abusers, having used three or more different substances in the six months prior to the survey, compared to 22 percent of the State's secondary school students as a whole.
- Black students had the highest rate of marijuana use. In the six months prior to the survey, 37 percent of Blacks had used marijuana compared to 34 percent of whites and 34 percent of Hispanics. On the other hand, Black students had lower rates of use on all prescription substances used non-medically, especially stimulants. Only five percent of Blacks had recently used stimulants compared to 17 percent of all the State's secondary school students.
- Black students, compared to students Statewide, are more likely to be exposed to others who are heavy users of marijuana. Sixty-seven percent of Black students compared to 61 percent of all students reported having close friends who get "stoned" or "high" on marijuana once a week or more.
- Alcohol use among Black students is less than Statewide figures. For example, 62 percent of Blacks reported using alcohol in the six months prior to the survey compared to 73 percent of the State's secondary school students as a whole.

- When asked where they would go if they had a drug or alcohol problem and needed help, Black students were much less likely to name friends (45 percent) than were secondary school students as a whole (64 percent). They were, however, more likely than all students Statewide to choose their parents (46 percent vs. 42 percent), a medical doctor (40 percent vs. 32 percent) or a program or counselor in school (35 percent vs. 29 percent).
- The majority of the State's Black students (72 percent) attend school in New York City.

Cocaine, one of the most highly addictive substances known, is now commonly used among adolescents, following marijuana and amphetamine use. Even more alarming is the fact that many younger persons are beginning to experiment with "crack," a purified form of cocaine that is smoked by inhaling the vapors given off when the drug is heated. The use of "crack" has spread in popularity among youth partly because it is relatively inexpensive and provides the "high" associated with cocaine in a more intense and rapid manner than other forms of use. While race-specific information is limited, use of "crack" has been reported particularly among Black youth. Extensive use of "crack" has been reported in all boroughs of New York City and surrounding suburban areas. "Crack" is widely available in Westchester County, and although it is not prevalent in upstate areas,it is also available in Buffalo, Utica, Albany, Schenectady and Troy (Governor's Briefing Paper on Crack 1986).

Interventions which discourage adoption of drug, alcohol and tobacco use could substantially reduce death and illness among Black youth and prevent chronic illness in later life. Substance abuse in this population promotes other risk-taking behavior, in particular accidents, homicides and suicides. Together these account for nearly three quarters of Black male teenage mortality and one third of mortality for Black adolescent females.

## Recommendations

Successful adolescent health programs recognize that adolescence is a difficult and transitory stage of life where special health problems must be addressed by persons concerned with and knowledgeable about the specific needs of adolescents. The crisis in public health care, increase in youthful substance abuse, pregnancies in early adolescence and interpersonal violence among young people are particularly critical problems for Black adolescents (Christmas 1976). The normal process of adolescent development, complicated by the influences of racism and poverty, make this an especially stressful period for many Black youth.

The socio-economic context in which many Black youth develop is the background against which their ability or inability to cope must be understood. The challenge is to begin efforts immediately to deal with pre-teens and teens at highest risk, before they are ill. For at-risk youth, particularly those who live in poverty, it is the responsibility of government to assist them in their developmental tasks,as well as with the problems of living which may prove critical stresses (Christmas 1986).

In the area of adolescent health the Subcommittee identified the increasing rates of homicide and suicide, teen pregnancy and substance abuse among Black youth as priorities. Therefore, an overall focus on comprehensive health care, including school health programs and preventive day treatment, is recommended. It is suggested that a comprehensive model to provide a range of health, social service, recreational and skill development activities would be appropriate.

Creative approaches to service delivery are required to meet the challenge created by this growing crisis among Black adolescents, as well as young adults aged 18-24 years-- the latter group being in particular need of services because of their "aging out" status in the traditional mental health delivery system. The Subcommittee recommends the following:

- The State should develop comprehensive adolescent health and mental health service programs in New York City (specifically Harlem and Bedford Stuyvesant), Westchester and Buffalo. These programs, under the auspices of a community mental health and/or health center with appropriate linkages to schools, hospitals, etc., would be multi-funded, focusing on early identification of at-risk youth with an emphasis on prevention, including prenatal care, health and social services, crisis counseling and education.

The Door in Manhattan is an excellent example of the type of comprehensive adolescent health services program which should be encouraged and supported as an institutionalized component of the adolescent health system in Black communities. The Council's Center For Problems of Living has developed a proposal for a comprehensive regional program model for Black youth, which would include targeted services in the Lower Bronx, Inwood, West Harlem, Washington Heights and Central Central Harlem.

- The State should implement a demonstration program of "presumptive eligibility." Such a program would presume all adolescents in specific geographic areas to be eligible for at least a first primary care visit. Presumptive eligibility would eliminate means tests, eligibility would be based on residence in areas with low socio-economic indicators.

- The State should provide alternatives to traditional mental health services to Black adolescents and young adults, for whom such services might otherwise be unavailable (i.e., truants, high school dropouts, homeless and/or shelter-based youth, etc.) through a variety of coordinated interventions and comprehensive programs, including, but not limited to a) walk-in and crisis psychiatric services, b) parenting groups for teenage mothers and fathers, c) family support services, d) short-term counseling, e) alcohol/substance abuse counseling and f) educational/vocational and general life skills.

- The State should increase the availability of and access to preventive mental health services to providers of primary health-care services in high-risk communities.

## APPENDIX A

## STATE TEENAGE PREGNANCY AND PARENTING PROGRAMS,1986

## NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

### Income Maintenance (AFDC, HR, Foster Care)

Provides grants to eligible individuals or families which can be used to supply basic needs, food and shelter. AFDC is funded 30% by federal government with 25% State and 25% county government match. Home Relief is funded 50% by State and 50% locally.

### Family Planning (Title XIX, Title XX)

Provides services through Title XIX (Medicaid) and Title XX funding. Federal participation is available at 90% for these services. Physicians and other Medicaid providers are reimbursed directly by the Department of Social Services through the Medicaid Management Information Systems (MMIS).

### Unmarried Parent Services (Title XX)

Provides or arranges for supportive health and social services for an unmarried mother and a child born or to be born to single parents. Allocation for 1985 is slightly over $3 million approximately half of which is expended on services to adolescents.

### Adolescent Pregnancy Prevention and Services Program

Develops and expands prevention programs aimed at decreasing the incidence of adolescent pregnancy; provides for the establishment of a comprehensive and coordinated approach to prevent initial and repeated pregnancies, addresses the consequences associated with adolescent pregnancy. An initial appropriation of $5 million of State funds was allocated for this program.

### Residential Shelters

Provides residential care and supportive services to pregnant teens until shortly after delivery. Supportive services include health and nutrition education, parenting skills, and after care services. There are four shelters in New York City, the remaining four are Upstate.

### Infant Day Care (Title IV-C)

Provides services for all employed AFDC recipients, those enrolled in an approved vocational program, and youth seeking to return to high school. The State budget appropriates $6.125 million for day care. Title IV-C provides funding for child care in conjunction with job training and placement services to AFDC recipients participating in the Work Incentive Program (WIN).

### Child Care Title XX, Title IV-C, JPTA Title II

Provides services which include assessing the need for child care, providing, supervising, monitoring, and evaluating the provision of care for children 6 weeks to 14 years in licensed day care centers and licensed certified family day care homes. Funds are provided through Title XX of Social Services Block Grant funds to the State. Title IV-A funds are available from JTPA Title II funding through "needs - based payments".

### Child/Teen Health Plan (CTHP)

Provides early and periodic screening diagnosis and treatment to all Medicaid eligible individuals under 21 years of age to help prevent disease and disability. This program, formerly titled the Child Health Assurance Program (CHAP), is administered by local social services districts under Title XIX (Medicaid) regulations.

### Teen Services Act (Case Management)

Chapter 975 of the Laws of 1984 provides for the establishment of a statewide system of case management services, under the auspices of local departments of social services, to pregnant, parenting and at-risk adolescents on public assistance. This law allows case management to be administered directly by social services districts or through sub-contracts with other agencies.

## NEW YORK STATE DEPARTMENT OF HEALTH

### Family Planning

Provides services such as pregnancy testing, contraceptive services, alternatives counselling, STD and gynecological care and a broad range of preventive health care. The Department of Health in fiscal year 1984-85 received approximately $3.1 million from State legislative appropriations, $800,000 from the federal Maternal and Child Health Block Grant and $4.7 million through Title X of the federal Public Health Service Act to fund family planning services.

### Supplemental Food Programs for Women, Infants and Children (WIC)

Provides both supplemental, nutritious food and health care to pregnant women, infants and young children in order to prevent the occurrence of physical and mental health problems. The Federal Department of Agriculture makes grants to state health departments, which administer the WIC program through various public and not-for-profit providers. For fiscal year 1984, the spending authorization level for New York State was $129 million.

### Infant Health Assessment Program (IHAP)

Ensures that infants and young children at high risk for physical and developmental disabilities receive the screening, diagnosis and follow-up treatment needed to prevent or ameliorate disabling conditions. The children of adolescent parents are specifically targeted for services within IHAP. $1 million was allocated to the program in 1986.

### Linkage Program (Comprehensive Case Management)

Provides comprehensive, coordinated services to pregnant and parenting adolescents so as to enhance pregnancy outcomes, reduce the incidence of repeat pregnancies, increase the number of adolescents completing their education and assist pregnant and parenting adolescents to obtain job skills leading to employment and self-sufficiency. Currently there are 16 funded projects with a total budget of over $1.5 million.

### Prenatal Care/Nutrition Services (PCNP)

Provides high quality prenatal care and nutritional services to low income women ineligible for Medicaid and without other forms of health insurance. Education and outreach activities are a major feature of the program. State funding for the program in 1986 was $7.5 million.

## NEW YORK STATE DEPARTMENT OF EDUCATION

### Family Life Program

Assists local school districts and Boards of Cooperative Education Services in developing community - specific strategies for addressing adolescent pregnancy in schools. The allocation for the 1985/86 fiscal year was $100,000.

### School Health Services Demonstration Program

Assists children and adolescents in gaining access to improved health care by utilizing the capability of educational institutions to provide an expanded type of school health service. The State Department of Education, through the Bureau of Health & Drug Education currently administers nine School Health Services Demonstration Programs across the State. State funding of approximately $400,000 supports several on-site health services in three selected school districts in Buffalo, New York City and Newburgh.

### School Breakfast and Lunch Program

### Vocational Education Programs

## NEW YORK STATE DIVISION FOR YOUTH

### Youth Development/Delinquency Program

Provides funds for local recreation and youth services. Allocation for 1983 totalled approximately $42.2 million. These funds are matched by counties at a level of 50 percent $13.6 million with 1/3 allocated to New York City and 2/3 to Upstate programs serving at risk, pregnant and parenting adolescents.

### Special Delinquency Prevention Program

Provides up to 100 percent reimbursement for community based services designed to divert high risk youth from problem situations and behavior. Total SDPP allocation for 1985 totals $12.4 million with approximately $1.6 million to programs related to adolescent pregnancy.

### Youth Initiatives Act

Provides for specific services for youth. These services include counselling for Persons In Need of Supervision (PINS). This Act assists local community-based programs by appropriating additional funds.

### Runaway and Homeless Youth Act

Provides crisis intervention services for runaway youths. Emergency services are provided for up to 60 days. These services are funded at $2.5 million. This Act also provides for longer term stay for youths who have no homes. This transitional period ranges from six months to one year. The program is funded at $2 million. The youth who receive services are not necessarily court cases.

## APPENDIX B

### VIOLENCE PREVENTION STRATEGIES

### BOSTON YOUTH PROGRAM VIOLENCE PREVENTION CURRICULUM (BYP)

A comprehensive health care initiative for adolescents which offers hospital or clinic-based health services and school-based health education prevention services; a violence prevention curriculum developed for tenth grade health students is one of the health education services.

Students are receptive and enthusiastic about a curriculum on anger/homicide; program has a significant impact on both their attitudes and their knowledge; further study required to determine impact of curriculum on behavior and longevity of impact.

### YOUTH AT RISK PROGRAM (YAR)

The Youth at Risk Program of the Breakthrough Foundation is a San Francisco based program for teenagers who are in serious trouble. The program has two components, a 10-day intensive experience and a six to twelve month follow-up. Their clients are described as those youth who are failing in school or have been expelled, who are dangerously violent, who break the law, who fight with their families and who are strung out on drugs or alcohol.

A reduction in recidivism rates increased over time after the 10-day course and was statistically significant after only seven months. The YAR program is responsible for these positive results.

### PEER DYNAMICS (PD)

Peer Dynamics, a school based program, 1977-1980, was sponsored by the Nebraska Commission on Drugs in Lincoln, Nebraska. The program was designed to reduce the incidence of the destructive risk-taking behaviors of juvenile delinquency and drug alcohol abuse among school age youth. Recognizing the importance of peer pressure, Peer Dynamics instituted peer education and counseling systems in fifty-six Nebraska public schools. The program trained and supervised students who participated in a group interaction plan with other students to develop self-esteem and better communication skills.

### TAKING CHARGE (TC)

A school-based program for drug abuse and dropout prevention, which has a model applicable to violence prevention in the Mesa, Arizona public schools; developed in response to strict disciplinary drug policy instituted for grades 7-12; require suspended students to attend 8 weekly after school education/counseling sessions designed to improve self-esteem and teach factual information about drugs.

Taking Charge has a multi-institutional base including the schools, mental health department, local law enforcement agencies. Evaluation data is not yet available, however, those involved feel that it has reduced drug usage and has returned many students to school.

STRIKE II

A court based program linking juvenile justice with health care; a consolidated effort between John Hopkins Hospital Adolescent Programs and the Juvenile Justice System of Baltimore county; for postajudicator first time offenders (for violent crimes, assaults, robbery, arson, breaking and entering) sentenced to a standard probationary period; has program staff of counselors and legal staff; involves client's family; psychosocial evaluation component, on-going medical services, recreation, education, job readiness, on-going counseling, in addition to traditional probation services.

Recidivism rates for clients were considerably lower than those for standard probationers.

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Source: Prothrow-Stith, D., "Interdisciplinary Intervention Applicable To Prevention of Interpersonal Violence and Homicide In Black Youth," Federal Task Force Report on Black and Minority Health, 1985

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# IV. THE PRODUCTIVE YEARS OF LIFE: SELECT CAUSES OF MORBIDITY AND MORTALITY AMONG BLACK ADULTS IN NEW YORK STATE

The Black child who survives the hazards of childhood and the hurdles of adolescence enters adulthood where the social and economic requirements of life interfere with health status and vice versa.

A federal report released in November 1985 stated that the poor health of Blacks and other minorities causes 60,000 "excess deaths" a year. The report identified six areas that account for more than 80 percent of these deaths and reflect the health disparities between minority and white Americans: cancer, cardiovascular disease, chemical dependency, diabetes, infant deaths and, in a group together, homicide, suicide and accidents (Health System Plan 1985).

The leading cause of death for Blacks in their twenties in New York is homicide. (See Table 1) For Black men in their thirties the leading cause of death is AIDS followed by homicide. For Black women who die in their thirties most deaths are caused by cancer and cirrhosis of the liver. The leading causes of death for Blacks over the age of 39 years are heart disease and cancer.

## TABLE 1

### Leading Causes of Death By Age and Sex Among Black New York State Residents, 1984

| | MALES | | FEMALES | |
|---|---|---|---|---|
| **AGE** | **CAUSE** | **PERCENT** | **CAUSE** | **PERCENT** |
| 20-29 | | | | |
| | TOTAL DEATHS | 618 | TOTAL DEATHS | 272 |
| | Homicide | 39% | Homicide | 16% |
| | AIDS | 6% | Cancer | 9% |
| | Suicide | 6% | Heart Disease | 7% |
| | Non - M.V. Accidents | 6% | AIDS | 6% |
| | Motor Vehicle Accidents | 5% | Pneumonia/Influenza | 6% |
| | Injury (intent undeter.) | 5% | | |
| 30-39 | | | | |
| | TOTAL DEATHS | 1,111 | TOTAL DEATHS | 463 |
| | AIDS | 13% | Cancer | 14% |
| | Homicide | 12% | Cirrhosis of Liver | 10% |
| | Heart Disease | 11% | Heart Disease | 8% |
| | Cirrhosis of Liver | 11% | AIDS | 7% |
| | Cancer | 7% | Stroke | 7% |
| | | | Pnemonia/Influenza | 7% |
| 40-49 | | | | |
| | TOTAL DEATHS | 1,194 | TOTAL DEATHS | 692 |
| | Heart Disease | 21% | Cancer | 30% |
| | Cancer | 16% | Heart Disease | 21% |
| | Cirrhosis of Liver | 11% | Cirrhosis of liver | 7% |
| | Homicide | 6% | Stroke | 6% |
| | Pnemonia/Influenza | 5% | Diabetes | 3% |
| 50-59 | | | | |
| | TOTAL DEATHS | 1,809 | TOTAL DEATHS | 1,256 |
| | Heart Disease | 33% | Cancer | 36% |
| | Cancer | 26% | Heart Disease | 31% |
| | Cirrhosis of Liver | 6% | Stroke | 6% |
| | Stroke | 5% | Diabetes | 5% |
| | Pnemonia/Influenza | 4% | Cirrhosis of Liver | 5% |

In 1984 data on the age sex/race-specific death rates of New York State residents provided by the Department of Health show a number of striking and disturbing statistics:

- The death rate of Black men in their thirties is more than four times the rate of their white counterparts (7.7 per 1,000 compared to 1.8 per 1,000).
- For deaths due to heart disease, Black men in their thirties die at a rate nearly three and a half times that of their white counterparts (85 per 100,000 compared to 24.5 per 100,000).
- For deaths due to cerebrovascular disease Black men in their thirties and fifties die at a rate nearly five times that of white men of the same ages (18.7 per 100,000 compared to 3.8 for whites in their thirties and 104.3 per 100,000 versus 22.3 for whites in their fifties). For Black women in their thirties the death rate is more than seven times that of their white counterparts (17.4 versus 2.4 per 100,000).

The most startling statistic, however, is that for deaths due to homicide among Black men in their twenties, which is more than 15 times greater than the rate for white males of the same age (134.5 per 100,000 versus 8.6 per 100,000 for white).

- For deaths due to cirrhosis of the liver Black men in their thirties die at a rate which is nearly eight and a half times greater than that for white men of the same age (85.0 per 100,000 vs. 10.1). Black women in their thirties die at a rate six and a half times as great as their white counterparts (24.8 per 100,000 vs. 3.8).
- For deaths due to AIDS, Black men in their thirties die at a rate which is nearly six times that of white men (97.4 per 100,000 vs. 16.4) and Black women of the same age die at a rate over 22 times greater than the rate of white women (17.9 per 100,000 vs. 0.8).

These statistics clearly suggest that the average Black man who pays into the Social Security system does not live to collect it.

## Cardiovascular and Cerebrovascular Diseases

### Heart Disease

The leading cause of death in the United States and in New York State is heart disease. National data disaggregated by race show that the average annual death rates for heart disease, however, are higher for Blacks under age 70 than for whites. Under age 45, the rates for Blacks are also higher, among both men and women, than the rates for whites. Coronary heart disease (CHD) mortality rates are similar for Black and white men, but are greater for Black women than white women. The incidence of CHD is also greater among Black women, however, prevalence rates of CHD appear to be similar among Blacks and whites. National hospital admission data indicate higher rates of myocardial infarction for white men than for Black, which may be a result of higher rates of sudden death in Blacks prior to hospital admission (Health Systems Plan, 1985).

In New York State, adult Black males (ages 20-60 years) have a mortality rate attributable to heart disease which is nearly two and a half times that of white males (table 2). For Black females in the same age cohort, the mortality rate resulting from heart disease is nearly three times higher than that of their white counterparts. Both Black men and women in their thirties have a heart disease mortality rate which is three and a half times higher than that of their white peers (NYS Department Of Health 1986).

## TABLE 2

### Age-Sex-Race New York State Resident Deaths, Selected Causes Specific Rates Per 100,000 Population, 1984

| | Male | | | Female | | |
|---|---|---|---|---|---|---|
| **Heart Disease** | White | Black | Hispanic | White | Black | Hispanic |
| 20-29 | 4.5 | 12.9 | 5.6 | 3.2 | 8.6 | 4.8 |
| 30-39 | 24.5 | 85.0 | 32.6 | 6.1 | 20.5 | 13.0 |
| 40-49 | 132.5 | 227.5 | 114.2 | 37.3 | 100.9 | 28.2 |
| 50-59 | 392.8 | 656.1 | 413.5 | 131.2 | 316.1 | 136.0 |
| **Cancer** | | | | | | |
| 20-29 | 10.1 | 16.9 | 6.3 | 8.1 | 10.9 | 6.0 |
| 30-39 | 23.3 | 53.9 | 27.4 | 31.1 | 35.3 | 30.3 |
| 40-49 | 91.3 | 174.5 | 68.5 | 100.3 | 145.7 | 67.5 |
| 50-59 | 283.9 | 504.0 | 211.2 | 261.4 | 365.3 | 150.0 |
| **Cerebrovascular Disease** | | | | | | |
| 20-29 | 1.0 | 4.5 | 2.1 | 0.4 | 3.2 | 1.2 |
| 30-39 | 3.8 | 18.7 | 11.1 | 2.4 | 17.4 | 7.9 |
| 40-49 | 10.3 | 38.7 | 20.4 | 9.6 | 29.4 | 13.1 |
| 50-59 | 22.3 | 104.3 | 59.8 | 22.5 | 58.1 | 29.4 |
| **Homicide** | | | | | | |
| 20-29 | 8.6 | 134.5 | 129.5 | 2.7 | 19.6 | 18.5 |
| 30-39 | 7.1 | 92.6 | 108.0 | 2.6 | 12.1 | 10.1 |
| 40-49 | 5.7 | 63.0 | 97.4 | 2.3 | 12.6 | 12.1 |
| 50-59 | 4.3 | 40.2 | 65.1 | 1.1 | 8.2 | 2.8 |
| **Suicide** | | | | | | |
| 20-29 | 23.1 | 20.3 | 18.1 | 5.2 | 2.3 | 3.0 |
| 30-39 | 21.2 | 11.7 | 21.4 | 8.0 | 4.7 | 4.3 |
| 40-49 | 14.2 | 12.6 | 15.6 | 8.8 | 2.1 | 3.0 |
| 50-59 | 17.0 | 7.6 | 21.1 | 6.4 | 4.9 | 2.8 |

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TABLE 2 - CONTINUED

| | Male | | | Female | | |
|---|---|---|---|---|---|---|
| Cirrhosis of Liver | | | | | | |
| | White | Black | Hispanic | White | Black | Hispanic |
| 20-29 | 1.2 | 9.6 | 6.3 | 0.7 | 3.2 | 1.2 |
| 30-39 | 10.1 | 85.0 | 57.4 | 3.8 | 24.8 | 7.9 |
| 40.49 | 25.5 | 118.7 | 117.8 | 7.9 | 35.0 | 15.1 |
| 50-59 | 35.8 | 123.8 | 114.4 | 17.8 | 46.7 | 36.5 |
| Diabetes | | | | | | |
| 20-29 | 0.9 | 0.6 | 1.4 | 1.2 | 0.9 | 0.0 |
| 30-39 | 1.8 | 4.1 | 2.6 | 2.0 | 4.2 | 0.7 |
| 40-49 | 5.4 | 18.0 | 8.4 | 5.2 | 16.1 | 10.1 |
| 50-59 | 14.8 | 52.1 | 19.4 | 10.2 | 47.5 | 15.4 |
| Accidents | | | | | | |
| 20-29 | 50.9 | 37.1 | 29.2 | 11.8 | 8.2 | 2.4 |
| 30-39 | 32.9 | 35.6 | 30.0 | 10.8 | 8.4 | 7.2 |
| 40-49 | 27.2 | 41.4 | 21.6 | 13.2 | 8.4 | 11.1 |
| 50-59 | 27.3 | 45.6 | 29.9 | 9.2 | 14.7 | 14.0 |
| Aids | | | | | | |
| 20-29 | 4.5 | 21.9 | 26.5 | 0.8 | 7.3 | 8.3 |
| 30-39 | 16.4 | 97.4 | 84.0 | 0.8 | 17.9 | 15.2 |
| 40-49 | 18.7 | 50.4 | 58.9 | 0.3 | 4.2 | 3.0 |
| 50-59 | 5.9 | 21.7 | 19.4 | 0.2 | 0.0 | 0.0 |

SOURCE: New York State Department of Health, Biostatistics Division, May 16, 1986.

## Stroke, Hypertension and Hypertensive End-Stage Renal Disease

A major risk factor for heart disease and stroke is hypertension. National figures indicate that mean blood pressure levels are greater in Blacks than whites, and Blacks have a marked excess of hypertension (Health Systems Plan 1985). Mortality resulting from stroke is also higher among Blacks than whites, and a greater proportion of Blacks suffer nonfatal strokes. End-stage Renal Disease (ESRD) resulting from hypertension is a more common occurrence among Blacks than whites, and Blacks with hypertension are at much greater risk of developing ESRD than are whites (Health Systems Plan 1985).

New York State data in table 2 show that among Black adult males (20-60 years) mortality resulting from cerebrovascular disease is four and-a-half times greater than the rate for white males; for Black females the rate is five times as great and it is significantly higher for Black women in their twenties (NYS Department of Health 1986).

Access to care is an important issue relating to cerebrovascular disease. It has been well documented that Blacks make fewer hospital visits and are less likely to have been seen by a cerebrovascular specialist. This contributes to less frequent diagnosis of coronary disease in Blacks. Blacks are also less likely to undergo coronary bypass surgery. They are more likely to be seen in hospital clinics and emergency rooms and this has negative implications for continuity of care, especially important for a disease such as hypertension, which has a higher incidence in the Black population (Health System Plan 1985).

## Cancer

The Federal Task Force on Black and Minority Health found that Blacks have the highest overall age-adjusted cancer rates for both incidence and mortality of any U.S. population group. Blacks have an 11 percent excess mortality from cancer compared with whites and lower survival rates for 22 of the 25 primary cancer sites (types of cancer). Between 1978 and 1981 the five-year relative all-site survival rate was 50 percent for whites and 38 percent for Blacks (Health Systems Plan 1985).

The major risk factors for cancer are tobacco, alcohol, nutrition, diet, occupation and socio-economic status. Among Blacks nationally, tobacco-related cancers account for approximately 45 percent of new cancer cases in Black males and 25 percent in Black females; 37 percent of cancer mortality in Black males and 20 percent in Black females. Lower socio-economic status has been correlated with poorer cancer survival rates and is also related to increased cancer incidence for cancers of the lung, breast and cervix (Health Systems Plan 1985).

Data compiled by the New York State Department of Health Cancer Registry showed that for the period 1978-82 the age-adjusted and average annual cancer incidence rates for selected cancer sites were 448.6 per 100,000 for Black males and 279 per 100,000 for Black females compared to 391.2 for white males and 309.1 for white females. Specifically, Black males had higher rates of cancer of the lip, oral cavity and pharynx; esophagus; stomach; pancreas; layrnx; trachea, bronchus and lung; and prostate. Black females had higher rates of cancer of the lip, oral cavity and pharynx; esophagus; stomach; pancreas; and layrnx. They also had higher rates of invasive and non-invasive cancer of the cervix of the uterus. Furthermore, in New

York City, invasive cervical cancer has been diagnosed in more advanced stages in Haitian and English-speaking Caribbean Black immigrants than in U.S. born women (Fruchter et al, 1986).

Factors contributing to poor cancer survival in Blacks include lower socio-economic status, late-stage diagnosis, delay in detection and treatment, differences in biologic factors such as immune competence and response, histologic patterns of tumors and nutritional status. A number of studies support the hypothesis that the difference in the cancer experience between whites and Blacks may be largely attributable to social and environmental factors. In particular, a greater rate of exposure among Blacks, to certain kinds of toxins in the work place contributes to their increased incidence of cancer.This has major policy implications for access, availability, utilization, quality and distribution of health resources (Health System Plan 1985).

Cancer is the second leading cause of death for Black women in their twenties, thirties, forties and fifties in New York State. Among Black males in New York State, cancer is the second leading cause of death in their forties and fifties. For Black men (30-60 years old) cancer mortality is twice that of white men in the same age cohort. For Black women cancer mortality is nearly one-and-a-half times that of their white peers.

## Cirrhosis of the Liver

Alcoholism is the major cause of cirrhosis of the liver. There is disproportionately high mortality attributable to cirrhosis among Blacks nationally, a rate nearly twice the rate of whites (Health System Plan 1985).

As illustrated in table 2, among Black men (20-60 years old) in New York the mortality rate due to cirrhosis is more than six times that of white men, and is eight times higher in their twenties and thirties. Among Black women 30 - 60 years, the rate is one-and-a-half times higher than their white counterparts and nearly six-and-a-half times higher in their thirties (NYS Department of Health 1986).

## Diabetes

Nationally, the prevalence of diabetes is 33 percent higher in the black population than in the white. It is 50 percent more prevalent among Black females and is directly related to obesity. Complications of diabetes are also more frequent in the Black population than in the white (Health System Plan 1985).

According to the NYS Department of Health, approximately 4.5 percent (107,850) of Black residing in New York State have diagnosed diabetes; up to 4.4 percent (105,688) of Black New Yorkers may have undiagnosed diabetes. Surveys estimate the proportion of blacks with diabetes to be 16 percent higher than the proportion of whites. While diabetes is more prevalent among Blacks than whites, increased risk exists for Black women which is approximately twice the risk for Black men. Increasing risk with age is noted for both black men and women (NYS Department of Health 1986). In New York State, Black men (30-60 years old) have a mortality rate attributable to diabetes that is three times higher than that of white males of the same age. For Black women, the rate is also more than three times that of white women.

All diabetics are at increased risk of hypertension. In New York the estimated proportion of diabetics with hypertension is 53.8 percent. The presence of hypertension significantly increases risks for diabetic complications, e.g., amputation, blindness, kidney failure and heart disease (NYS Department of Health 1986).

## Acquired Immune Deficiency Syndrome (AIDS)

AIDS is rapidly becoming the most devastating disease to impact the Black Community. This debilitating syndrome is a critical problem affecting not only individual men and women but often whole families. Among women, the cumulative incidence of AIDS in Blacks is 13.3 times that of whites. Among Black women in their twenties the AIDS mortality rate is more than nine times higher then their white counterparts; nearly twenty-three times higher in their thirties, and fourteen times higher in their fifties (NYS Department of Health 1986).

Table 1 shows that AIDS is the leading cause of death among Black men in their thirties and the second leading cause of death for Black men in their twenties, preceded by homicide. Intravenous drug users are the second largest risk group to contract the fatal disease. Of the reported cases of Blacks with AIDS in New York City, 45.3 percent are IV drug users. Second to homicide, AIDS has been the major cause of death in many of New York City's predominantly Black neighborhoods; particularly in Central Harlem. To the extent that Blacks are involved in the intravenous use of drugs, they are at increased risk of potentially fatal infections from AIDS. Intravenous drugs users constitute the fastest growing percentage of the population with AIDS, representing over 33 percent of all New York City AIDS cases as of August 1986.

Blacks with AIDS do not live as long as their white counterparts. The average lifespan for Blacks with AIDS is 19 weeks compared to two years for whites. A number of reasons may account for this difference. It is possible that because IV drug users generally put off seeking medical help until the point of crisis, AIDS among this population is diagnosed at more advanced stages. Another suggestion is that Blacks have poor nutritional status and that poor nutrition exacerbates the debilitating effects of the disease. Thirdly, Blacks generally have less access to medical care, therefore, they are diagnosed later and treated for AIDS-related conditions in more advanced stages.

Women in New York are increasingly contracting AIDS. "In the past year, there has been an 81% increase in female AIDS cases, as a direct result of heterosexual transmission" (Woodman 1986). AIDS has become the fastest growing disease category for women. Poor, heterosexual Black women represent 52 percent of all women with AIDS. Most of them have contracted AIDS through current or past drug use, however, increasingly women are getting AIDS through sexual contact with men

In New York State, the majority of Blacks with AIDS are men (85 percent). Table 2 shows that among Black men in their twenties, the mortality rate due to AIDS is nearly five times that of white men, six times higher than that of white men in their thirties, nearly three times higher in their forties and three-and-a-half times higher in their fifties.

The Human Services Subcommittee of the Governor's Advisory Committee for Black Affairs has undertaken an in-depth study of AIDS in the Black community and made extensive programmatic and policy recommendations in volume 2 of the Advisory Committee's report series.

## Tuberculosis

The incidence of tuberculosis (TB) in New York and throughout the country has declined gradually since 1860, with the most significant declines occurring after World War II. This is attributed primarily to the introduction of antibiotics in TB treatment beginning with streptomycin in 1944. However, the battle against tuberculosis appears to be faltering, both nationally and in New York. There are still 20,000 new cases reported annually and 1,800 Americans die from tuberculosis. Many more are thought to die as a consequence of the disease, although often unrecognized, particularly among the elderly.

In New York City from 1975 to 1978, the rate of all forms of TB dropped 53.3 percent; however, from 1978 to 1982 the rate increased 24.8 percent, from 1,307 cases to 1,594 cases or from 18.1 cases to 22.5 cases per 100,000 population (NYC Department of Health 1986). In 1985, the tuberculosis rate increased to 26.1 cases per 100,000 population in New York City. According to Dr. H. William Harris, President of the New York Lung Association, the rate of TB increased 34 percent in the City between 1985 and 1986 compared to less than 1 percent nationwide. New York ranks fifth among the nations major cities in the number of cases per 100,000 population.

The rate of TB for Blacks greatly exceeded the average rates for New York State, New York City and Upstate New York in 1985. For New York State, the average TB rate was 14.0 per 100,000 population for Blacks it was 50.6. New York City had an average rate of 26.1; for

Blacks it was 57.9. The upstate TB rate in 1985 was 6.1; for Blacks it was 29.5 (Health System Plan 1985; NYS Department of Health 1986).

The recent increase in TB cases occurred citywide with the highest incidences in the Central Harlem, Lower East Side, Fort Green, Mott Haven, Morrisania and Bedford health districts. Central Harlem's rate of 106.6 per 100,000 in 1982 was almost twice the rate of the second-highest ranked district, the Lower East Side, which had a rate of 54.5 ( Health Systems Plan and NYS Department of Health 1985).

Males are more likely than females to have TB. Sixty-four percent of all TB cases in New York City in 1980 were male. Non-white males are at greater risk for TB (43.4 percent of total cases in 1982) than white males (21.5 percent) and females (10.8 percent) and non-white females (22 percent). Immigrants accounted for 42.2 percent of the total TB cases in 1980, however, they comprised only 23.6 percent of the population in the City (Health System Plan 1985). Blacks are four times as likely to contract TB as the population at large (NYC Department of Health 1986).

As with many diseases, TB is associated with adverse social and economic factors. It is fostered in areas which are densely populated, impoverished and overcrowded. Individuals at greatest risk of developing TB are alcoholics and persons with protein-calorie malnutrition, often the homeless and displaced individuals, whose numbers are increasing in New York. In addition, the possible relationship between AIDS and TB may provide an important explanation for the increase in cases (Health System Plan 1985).

The relationship between AIDS and TB is currently being studied by the New York City Department of Health. A number of the Department's studies have demonstrated a 30 percent increase in TB incidence from 1980-1984 among males aged 15 - 24. The majority of health districts with the largest increase in TB incidence were in areas with large populations of narcotic users, in predominantly Black and Hispanic neighborhoods, and/or homosexual men, identified high-risk groups for AIDS. By matching the TB registry during the period 1980-1984 with the AIDS registry and methadone registry, most of the increase in TB cases could be identified as occurring in AIDS cases (Health System Plan 1985).

It is likely that because of the accomplishments of national TB control programs in reducing the number of TB cases, these programs have received less priority since the late 1970s (Health Systems Plan 1985). The City's TB program is seriously troubled with poor followup, particularly among hard-to-track suffers. A continued increase of tuberculosis in New York City can be expected with the increase in drug abusers and homeless, unless actions are taken to prevent its rise.

## Mental Health

Despite the lack of data on the level of need or utilization of mental health services by Blacks in New York, it is known that the existing mental health services system has significant problems providing services to this population. Beyond the problem of providing culturally compatible and culturally targeted services and recruiting bicultural staff, "there is a continuing need to sensitize providers to cultural differences and to impress upon them their responsibilities for reaching out to underserved populations" (Health System Plan 1985).

New York State, with a large impoverished population, should be particularly concerned about stress-related mental illness. Poverty, particularly when linked with the pressures of single parenthood, low educational attainment and the presence of young children, is a major cause of emotional stress. Most of the stress suffered by poor Blacks is attributed to the lack of income necessary to meet basic human needs. Coping with stress can result in some very destructive responses, such as substance abuse, depression, violence and various forms of physical and mental illness (U.S. Commission on Civil Rights 1983). A multifaceted approach is required to relate to the varied mental health needs of Blacks. If the mental health system would address itself to the concept of ethnically concentrated high risk areas, those Blacks in need of mental health services would be better served.

For the chronically mentally ill Black population, the lack of residential facilities and programs in Black communities that would facilitate transition back into those communities is a serious problem. It is a problem related to the absence or deterioration of the housing stock as well as limited financial resources in Black communities. In addition, there are fewer rehabilitative programs in communities. Work is one important aspect of rehabilitation, however, the unemployment rates in most Black neighborhoods are very high. New York's homeless population, which is largely Black, poses another serious challenge for the State's mental health system, and that is, the combination of limited resources for the chronically mentally ill and their own sense of alienation from the larger community. Homeless Black families in shelters have a particularly critical need for on-site mental health and other services.

Preventive mental health should be a priority goal for New York State, by building on the strengths within the Black community to help families, enhancing the institutions that are located there and establishing preventive and supportive mental health programs.

## Recommendations

The most critical issues for Blacks in the adult phase of the life cycle are lack of resources and access to services. The preceding discussion has emphasized the fact that New Yorkers are dying from preventable illnesses at rates that are much higher than the rates of white adults. The key to improving the health status of Blacks is intervention/prevention efforts in early life, infancy through adolescence. The Subcommittee on Health has recommended a number of interventions for these early stages of the life cycle which, if implemented, will have lifelong benefits for Blacks in their most productive years. As it is for children, the primary requirement to improve health status of Black adults continues to be resource allocation for education and adult literacy, housing, employment opportunities and health services.

There is a need to replace the existing crisis-oriented system of health care, relied on by a substantial number of Black adults in New York, with an accessible prevention-oriented health care system. Continuing access to quality care can improve the outcome of illness, decrease hospitalization and save resources. Many of the unsatisfactory treatment outcomes in patients with preventable causes of morbidity and mortality could be averted by programs that emphasize and implement early detection, optimal patient evaluation, education and access to continuing follow-up treatment by adequately and appropriately trained professionals operating as a team.

The health problems which affect the Black adult population with greatest prevalence are conditions which, to a large extent, are either preventable or amenable to effective early detection and intervention. The increasing incidence of cancer, cardiovascular diseases, predominantly hypertension and stroke, diabetes mellitus, chemical dependence complications and AIDS are foremost in this population, and are responsible for morbidity which can be significantly reduced.

- The State should develop Statewide comprehensive community control programs which would be targeted at the aforementioned problems via screening, data collection and prevention.
- The State should modify existing Medicaid eligibility to expand the numbers of poor who would qualify.
- The State should provide improved access to health services by improving and expanding services and/or facilities in underserved areas. Priority for

expansion should be given to existing providers with a history and track record for service provision in the Black community.

The Subcommittee's recommendations in the area of mental health for Black adults place primary emphasis on two populations: homeless families in shelters and the IV-drug abusing AIDS population.

## Services for Homeless Families

- The State should fund and provide on-site service teams for homeless families in shelters. In addition to the State Office for Mental Health, the Department of Health, Department of Social Services, the Division of Housing and Community Renewal, Division of Alcoholism and Alcohol Abuse, Division of Substance Abuse Services should all contribute to this effort to ensure continuity in programs and services. These on-site teams, would offer a comprehensive range of services using a case management approach. Services would include mental health, preventive and general health care services, as well as social services. Recreational activities in the shelter would also be imperative.

## Aids

The Human Services Subcommittee of the Governor's Advisory Committee for Black Affairs has formulated extensive policy and programmatic recommendations related to AIDS in the Black Community. These recommendations are contained in volume 2 of the Committee's report series.

- The State should immediately establish Statewide programs to begin prevention education and support programs for Blacks with AIDS.
- The State should immediately increase the representation of Blacks on its planning and policymaking bodies, councils, and committees addressing the issue of AIDS.
- The State should also increase the funds allocated for already existing drug and alcohol treatment programs and Black social services agencies with a history and successful track record in service to the Black Community.

## Information and Diffusion

Although there is probably no single reason for the disparity in mortality for preventable causes of death between Blacks and the rest of the population, it is likely that some of the reported differences in the health status of Blacks are a result of the limited effectiveness of past information efforts, developed with insufficient consideration and understanding of the cultural context, background and diversity of Blacks in New York (Lythcott 1986).

- The State should mandate the development of an accurate data base on all ethnic populations in New York. The terms minority, non-white, and other have become irrelevant in the collection and interpretation of vital statistics. Among Black New Yorkers, specific data on native born Blacks, Caribbean Blacks and Africans are more appropriate categories for health information reporting purposes.
- Related to the issue of data is access to information. The State should assure that public health professionals at all levels of service provision and planning have access to information about Blacks which would assist them in their local planning efforts.
- Diffusion strategies aimed at ethnic and culturally diverse populations are more likely to be successful if they are planned at the community level, not at city, state or federal levels. The State must develop a partnership between local communities and government. Ethnic communities need funding and technical assistance to identify their own problems and develop their own culturally relevant methods of solving them.

## MENTAL HEALTH

New York's mental health system must embrace the concept of ethnically concentrated high risk areas in order to better meet the needs of Blacks.

- The State should direct major mental health funding into the Black community for community-based services, specifically residential rehabilitative care and case management services.
- The State should establish crisis counseling centers and develop a range of day treatment programs in the Black community.
- As recommended by the Minority Advisory Committee of the State Office of Mental Health, the State should establish an Institute for Mental Health Research and Policy on Racial Minorities.

The Minority Advisory Committee of the State Office of Mental Health has found that racial and ethnic minority clients tend to be seen in the less expensive treatment modalities of medication groups, group therapy, etc.

The State Office of Mental Health should be required to collect and analyze data on a racial and ethnic minority basis. There is an ongoing need for advocacy on behalf of racial and ethnic minorities within the New York State Office of Mental Health. In addition, there is also a need to reflect treatment outcome on the basis of racial and ethnic minority populations.

- The State should identify Black mental health professionals for appointment to middle management and administrative positions.
- In-service training and retraining are essential components of providing quality and appropriate mental health services. Culturally appropriate training and treatment modalities should be emphasized in mental health service programs. The tendency to use outside consultants from around the country however, results in training which is, at times, more appropriate to other areas of the country, such as the Southwest.

- The State should initiate research on the design of mental health treatment programs that will address issues of particular concern to Blacks and encourage the use of researchers in State mental health consultant contracts.

The Federal Task Force Report on Black and Minority Health found that chemical dependency, homicide and suicide, family violence, cardiovascular disease, stroke and hypertension, diabetes and its complications, infant mortality and cancer are illnesses which disproportionately affect Blacks. With regard to these illnesses, the antecedent and complicating roles of mental health should be assessed and the State must redirect its resources to targeted programs that address these problems. Furthermore, the aforementioned problems occur more substantially in Black mentally ill patients. (Calabrese et. al 1987). Multiple diagnoses are prevalent in this population.

- The State must make targeted treatment of the Black mentally ill a priority. Adult health problems in the Black community include neglect of personal health care, inadequate access to specialized services and insufficient health providers.
- The State should subsidize the training of medical and allied health professionals who will serve Black communities, establish satellite clinics with simple registration procedures and hours convenient to the working adult.

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## V. HEALTH CARE SERVICES FOR THE BLACK ELDERLY
## THE CHALLENGE FACING NEW YORK STATE

Contrary to the popular notion that the elderly years are to be lived leisurely, most aged Black people continue to confront the same problems of their adult lives. Not only do poverty and the resultant poor living conditions stay with them, but their physical strength begins to deteriorate. The statistical data indicate that Black people suffer and die in alarmingly high numbers from a variety of diseases. These data also reveal that debilitating poverty is a chief cause of the excessive morbidity and mortality.

In general, the Black aged are in poorer health than are the white aged. Elderly Black men and women live shorter lives and die more frequently from chronic diseases than their white counterparts. In 1983, life expectancy for Black males was 65 years as compared to 72 years for white males. Similarly, life expectancy for Black females was 74 years as compared to 79 years for white females (Allen 1986). Black men die most frequently of the leading causes of death of all elderly people. The causes, listed in descending order, are: heart diseases, cerebrovascular diseases, cancer, accidents, pneumonia/influenza, chronic liver disease/cirrhosis and diabetes mellitus. Black men died twice as frequently from liver disease and cirrhosis than did white elderly men. Black women, similarly, died of all of the aforementioned diseases at a higher rate than did white women (Morrison 1985).

Furthermore, data comparisons between 1960 and 1980 reveal that for all sex/race groups, death rates for heart diseases and cerebrovascular diseases decreased, however, the decline was least for Black males. On the other hand, deaths from cancer increased for each race/sex group with the greatest increase among Black males. Statistics also indicate that Blacks aged 65-plus had more disability days and restricted activity days due to chronic diseases and disability as compared to both whites and other minority aged (Morrison 1985).

Clearly, improper dietary habits and the excessive social habits of drinking and smoking contribute significantly to the prevalence of morbidity and mortality among elderly Black people in general, and Black men in particular. Poverty increases the risk and severity of illness and lessens the likelihood that the disease will be properly treated. Health care services, most readily available and utilized by the poor, are neighborhood clinics and public hospital emergency rooms. In both settings, the individual is treated by the first available doctor for the immediate symptoms (Allen 1986). In fact, a study conducted by New York City Department for the Aging revealed that 20.5 percent of the Black elderly sampled were without access to a physician as opposed to only 3.6 percent of the white. Furthermore, 28.4 percent of the Blacks sampled saw a doctor in a clinic rather than privately, in contrast with 6.8 percent of their white counterparts (Engler 1980).

According to a recent New York State Office for the Aging report, Black elderly people at New York State are highly concentrated below or at marginal poverty levels, particularly below poverty. Half of all Black elderly persons (49.5 percent) are below or at the marginal levels: 29 percent below poverty and 20.5 percent in marginal poverty.

Below poverty is defined by an annual income of less than $4,775 and marginal poverty is equivalent to an annual income of $4,775 to under $7,163.

The Black elderly's dependence upon restricted incomes supplied by federal monies rather than private savings and assets, partially explains their high rate of poverty. In 1981 Social Security (47 percent) and other income (10 percent), primarily Supplemental Security Income, accounted for 57 percent of the total income of Blacks 65-plus in the U.S. (National Caucus and Center on the Black Aged 1985). Among elderly Blacks living alone, these two sources represented almost three out of four dollars received (73 percent). Social Security and other income accounted for 62 percent and 11 percent, respectively (National Caucus and Center on th Black Aged 1985).

In spite of the disproportionately high Black morbidity and mortality rates, and staggering level of poverty within the Black community, Black people are living past age 65 at a steadily increasing rate. From 1970 to 1980, the number of Black people over the age of 60 in New York State increased by 40.1 percent, an increase of 70,255 persons, from 175,049 to 245,304 (NYS Office for the Aged 1986).

Although Black elderly over the age of 60 and age 75 comprise only 10 percent and 2.3 percent of the State's total Black population, respectively, New York State has the largest number of Black elderly people in the country. Projections for New York State are not available, however, nationally, more than 2.2 million Blacks were 65 or older in 1983. Almost 3 million (2,975,000) Blacks will be 65 or older by the year 2000 and by 2030 that number will reach 7.3 million in the U.S. (NYS Office for the Aged 1986).

The health care system alone cannot meet the needs of the indigent Black elderly. Issues of economics and class directly influence access to health care. The interplay between socio-economic status and health status is a critical one. The health status of all Blacks, including the elderly, can be improved as much, if not more, by adequate income and reduction in the rate of poverty than by even major changes in the health care system.

## Financial Access

Many problems beseige the health-care system and are immediately evident in the processes by which individuals pay for their care. Over the years Americans have been spending larger sums of money on health care. More dollars are spent on hospital and nursing home care than dental care, drugs, eye glasses, other health aides and health services (i.e., services of registered nurses and practical nurses, visiting nurses and physical therapists) (Morrison 1986).

Between 1970 and 1982, hospital care costs in the U.S. increased by 332 percent; nursing home costs by 404 percent. These were the highest percentage increases of all major health care services. Related to these increases, the amount of money spent per capita expanded by 326 percent for hospital care and 364 percent for nursing home care during this period. In fact, according to the Select Committee on Aging, the nation's elderly spent an average of $1,660 in 1985 for health and long-term care, over 15 percent of their income.

A 1985 study on long-term health care reported that persons with lower incomes are more likely to spend a higher proportion of their income on health care, costs and insurance premiums than are persons with higher incomes. Households with incomes of $10,000 or less, for example, are estimated to spend 56.6 percent of their income on health services and insurance, compared to 2.2 percent for families with incomes above $75,000 (Morrison 1986). Black males, nationally, have a median income of $8,345 and spend an average of $1,154 on health care, which amounts to 14 percent of their income. Black women spend the same amount, $1,154 of a substantially lower median income of $4,812 so that out-of- pocket spending is 24 percent of their income. These median income figures are based on gross income and, therefore, underestimate the percentage of net income spent on health services and insurance premiums (Morrison 1986).

Medicare primarily covers acute illnesses associated with hospitalization (70 percent of Medicare expenditures) so that the services needed most by elderly people are not covered -- routine physical examinations, foot care, eye or hearing examinations, immunizations and routine dental care, including treatment, filling, removal or replacement of teeth. In addition, Medicare's cost-sharing hospitalization requirements (deductibles and copayments) are financially exacting for poor Black people. These payments have continued to increase since Medicare's enactment in 1966. Because Medicare does not cover preventive services, Black elderly persons delay seeking care until illness becomes critical and requires hospitalization.

Nursing home care is limited under Medicare. Individuals in nursing homes are often forced to "spend down" their resources until they are eligible for Medicaid, which covers nursing home care in full. Therefore, Medicaid provides long-term care insurance by default. The new payment system under Medicare reimburses hospitals a fixed amount for the care of all patients in the same DRG (Diagnosic Related Group). This group is based on a set of assumptions about the time it should take to stabilize the illness and the extent of resources consumed per hospitalization for patients in the particular DRG (Allen 1986). The impact of DRGs is another issue which particularly concerns the Black elderly. With the advent of DRGs, the Black elderly, who generally present more complicated cases and longer lengths of stay cases, are the classic profile of the type of patient that is undesirable to a hospital. The issues of access and premature discharge are very significant for this population.

Related to the issue of DRGs is RUGs (Resource Utilization Groups), the reimbursement mechanism applied to nursing homes. Under RUGs, nursing home patients are classified into categories by service utilization. RUGs serve to drive out of nursing homes those who have traditionally been physical aid or low-care patients. Previous to RUGs, nursing homes were able to increase revenue by caring for people who did not require heavy nursing care. In fact, the most debilitated patients were the ones least desirable to the homes. Under RUGs, nursing homes are actually reimbursed at a higher rate for sicker and more debilitated patients. As a result, they now have a disincentive to admit those low-care patients.

Many of these low-care patients would be suitable for home care in the community. Unfortunately the situation is one where hospitals are pushing people out under DRGs, nursing homes are not taking them in under RUGs, and community-based home care services are underdeveloped. The impact of these and other reimbursement mechanisms on the Black elderly needs to be critically examined.

Medicaid's Personal Care Program under the State Department of Social Services is the largest provider of home care services in New York State. The problem is that in New York State a large number of Black elderly hover just above Medicaid eligibility, but do not have the personal resources to purchase home care. As a result, they are largely unserved by community-based services. What many Black elderly need are housekeeper/chore services and personal care services. Some do need home health-care services, but not heavily medicalized home care. Thus, there needs to be an expansion of home-care services and community-based support services for that near-poor category of older people whose incomes are above Medicaid eligibility.

The Medicaid program, the medical component of the federal/state public assistance program, was enacted to meet the full range of health-care needs of poor people of all ages. However, because Medicaid has become nursing home insurance, a growing proportion of Medicaid dollars are being spent on nursing home care. In fact, 71 percent of the State's Medicaid dollars in FY 1983, that were spent on the elderly (65-plus), went to nursing home care. The majority of these people, mostly elderly white women, were not poor prior to entering the nursing home, but became poor as a result of the exorbitant cost of care and limited Medicare or private insurance coverage. Consequently, Medicaid only served 23 percent of New York's Medicaid-eligible elderly population (Allen 1986).

## Institutional and Non-institutional care

The Black aged face two problems in terms of institutional care: fragmentation of services and discrimination in access to services, particularly nursing home services. First, all elderly people confront a health system in which their needs are handled under several different programs and agencies. The result is that often times their needs are met inappropriately or not at all. Also, many communities do not have the facilities to provide specific services. Second, racial discrimination and insensitivity continue to permeate health and social services. In 1985, the Black elderly were only 6.9 percent of

New York State's nursing home population. This low percentage may be attributed in part, to the financing problems posed by Medicare; the Black aged's lack of knowledge about nursing home services; the State's shortage of nursing home facilities; and discrimination in admission practices. Those Black patients who are admitted frequently complain of isolation and staff insensitivity in non-minority-managed nursing homes. Staff display their insensitivity by disregarding religious holidays and food traditions or by overtly racist behavior.

A study conducted by Barbara Jones Morrison reveals that Black patients had varying opinions regarding the necessity for racially matched staff and residents. Many thought that Black staff were more desirable because Black people understood one another while others maintained that as long as the staffers were kind, their color was unimportant. In spite of these differences of opinion, the study's participants agreed that Black cultural traditions should be recognized and incorporated into the activities provided by nursing homes (Morrison 1979).

Although substantial resources are spent on institutionalization, most elderly people need and prefer the services provided in the home by family and friends. This preference, however, for informal support systems should not obscure the reality that many elderly Black people cannot rely upon these resources for a variety of reasons, including the absence of spouse and/or children. A study conducted by the New York City Department of Aging, found that over half of the Black elderly in the sample (51.6 percent) had no children and a similar percentage (52.3 percent) had only one child (Engler 1980). Of all elderly households in New York State below the poverty level, 77 percent are elderly persons living alone (NYS Office for the Aging).

Therefore, while some friends and family of the Black aged provide personalized care that cannot be matched by formal caregivers is admirable, this has limited application. As statistics show, many elderly Blacks have few informal channels upon which to rely. Informal care, moreover, should not be equated with quality or adequate care. The care of a frail elderly person often presents both emotional and financial responsibilities which few are prepared to assume. And the assumption that Black elderly people are being cared for by their "extended family" has led providers to be less than earnest in assuring that Black people avail themselves of the services to which they are entitled.

There are more older people in need of home care than either hospital care or nursing home-care and the issues surrounding the financing and organization of home care in New York State are complex. This report would be incomplete without some mention of home-care. Medicare coverage for home-care is very limited and its reimbursement focuses almost exclusively on home health-care, which is medically oriented and most suitable to meeting the post-acute care needs of recently discharged hospital patients. Persons in need of ongoing housekeeper/chore or personal care assistance will not obtain this type of care under Medicare, and yet this is what most older people with chronic conditions require.

There is a need for a well-trained pool of home care workers. The home care industry has documented high turnover-approximately half of all home care workers leave within the first year. The majority of home care workers are middle-aged Black women, many of whom are from the Caribbean. Low salaries and lack of benefits, as well as lack of opportunities for career development make this field less unattractive.

The best personal care program in New York State is the Medicaid Personal Care Program. The issue here is that people must be eligible for Medicaid to qualify ( i.e., annual income of less than $4,908 for an individual and $7,200 for a couple). Although many older Blacks will meet these income requirements for Medicaid, a considerable number of "near poor" will not and it is this group which is largely unserved. The New York State Office for the Aging has established a new program, "Expanded In-Home Services to the Elderly" which is targeted to the "near poor" and applies a sliding-fee scale so that people can pay only what they can afford for home-care services, without having to totally impoverish themselves and "spend down" to Medicaid eligibility. There is a clear need for many more services of this type and the Black elderly would benefit from them.

## Health Service Delivery

The needs of the Black elderly include preventive services, home-care, comprehensive care for chronic and acute diseases and long-term care. In particular, preventive health services may ameliorate and, in some cases, reverse the effects of certain disabling conditions. Again, a primary focus on those Black elderly who are still well and functioning is imperative. For them, the priority must be prevention and health maintenance. Unfortunately, the delivery of health services is not only undermined by their high costs, but by the inadequate policy coverage of insurance companies. Furthermore, the limited financial resources of Black families make informal caretaking of the elderly especially burdensome. Unfamiliar with the process of accessing programs or of obtaining information about existing health-care services, the Black elderly are particularly affected by the fragmentation of services. And finally, racial discrimination continues to permeate the health and social services systems.

In addition, home care and home-health care are major issues for New York State in caring for its Black elderly. A common public health goal ought to be to keep people out of nursing homes as long as possible. Therefore, there is a need to have good community-based supportive services in the home.

New York State's Office for the Aging, Department of Social Services, Department of Health, Office of Mental Health, Division of Alcoholism and Alcohol Abuse, Office of the Advocate for the Disabled and Commission on Quality of Care For the Mentally Disabled all address the health and health-related needs of the elderly. Older Blacks are very much in jeopardy because of fragmentation of planning and delivery. The State Office For the Aging has implemented a formal policy which ties funding allocations to targeting on the basis of frailty, low-income and minority group status. The need for case management is critical. The definition of case management is the composite of five components: (1) intake and screening, (2) assessment and reassessment, (3) comprehensive care planning, (4) service acquisition and (5) monitoring and follow-up (Dennison 1987).

The Subcommittee on Health places particular emphasis on the need for coordinated and focused State policy on the targeting of health services to the Black elderly. As an example, a model policy is implemented by the State Office for the Aging, which targets three groups: the frail elderly, the low-income elderly and minority elderly.

In New York State, educating the Black elderly to increase their awareness of existing services is a major need. Many Black elderly do not know what services are available. The State Office for the Aging, in recognition of this problem among older New Yorker's in general, has increased the amount of written information it has on available services. However, more nontraditional methods of outreach may be required to reach the Black elderly, whose literacy rates are not as high as those of other elderly groups.

Of particular concern is the decreasing minority participation in aging services and programs, despite the fact that the minority population in New York State increased by over 45 percent between 1970 and 1980. Aging services and programs are not only underutilized, they are decreasingly utilized by minority elderly. This again implies the need for targeting as well as outreach. Some specific barriers to minority participation include discrimination; an absence of providers with racial/ethnic backgrounds similar to those of the minority elderly; lack of knowledge/information about services, benefits and entitlements; language; cultural differences (cultural attitudes toward aging, asking strangers for assistance and joining social organizations differ) (Holmes 1985). Although specific information on barriers of particular relevance to New York's Black elderly is not available, the aforementioned obstacles are likely to affect this population group as well.

## Recommendations

In the area of elderly health, the Subcommittee has identified these priority issues: (1) organized advocacy, both legislative and individual, on behalf of the Black elderly; (2) expanded training for care providers, particularly home attendants and home health-care providers; and (3) specialized housing for independent living.

- The State should offer broad-based training, re-training and specialized training for home-care workers, improved salaries for care providers, and enforce standards to assure quality care.
- The State should ensure that there are available short-term and long-term home health-care services for the elderly with physician or mid-level practitioners who would make periodic home visits, particularly to those elderly residing in predominantly Black communities. There is an even more critical need for non-medical home care which must also be made available and accessible in Black communities.
- The State should develop more home-care programs such as cost-sharing/sliding fee scale programs targeted at the near-poor category of individuals whose incomes are too high to qualify for Medicaid, yet too low to pay out-of-pocket expenses for medical care.
- The State should develop a health program which would place mid-level and allied health practitioners, who are trained in geriatric care, at Senior Centers located in predominantly Black communities.
- The State should ensure increased access, through mechanisms such as case management, and availability of services to the Black elderly, with particular emphasis on acute care, nursing home care, chronic care and home care services.

- The State should develop public service announcements (PSAs) targeted at the Black elderly focusing on available services and initiate collaborative efforts with public and private organizations to conduct a public education/information campaign targeted at the Black community.

Problems among the Black elderly include inadequate services for the elderly who wish to remain in their own homes but require minimal assistance, lack of information about and access to existing services, too few skilled nursing facilities for patients requiring long-term nursing care.

- The State should improve the quality and availability of home-care services and extend skilled nursing care to those elderly persons requiring long-term care and increase the availability of acute care, nursing home beds and day-care facilities in areas with predominantly Black populations of elderly.

## APPENDIX C

## NEW YORK STATE OFFICE OF THE AGING (SOFA)

## POLICIES AND PROGRAMS AIMED AT INCREASING BLACK ELDERLY PARTICIPATION

### TARGETING INITIATIVE

The purpose of the initiative is to increase participation among target populations (i.e., frail, minorities and low-income). Components of the initiative include:

- Joint Targeting Policy Statement of SOFA in conjunction with the Area Agencies on Aging (AAA):
- The role of SOFA in targeting is to stimulate the development of State and federal public and private initiatives and ensure the conduct of local activities that clearly increase the participation of target populations in service systems.
- The role of AAA in targeting is to focus client targeting, program targeting, and system development activities on the identified target populations.
- Two-day Intensive Training Program: Agency staff participated in order to clarify the policy and to increase their capacity to provide technical assistance.
- Regional Meetings: AAA and SOFA meet on the topic of targeting, with a major focus on targeting the minority elderly to increase their ability to do effective outreach, to involve the Black elderly in the planning and development of policy and to increase the quality of programming at congregate meal sites.

### FOOD PREPARATION

Representatives of SOFA's nutrition staff worked with the Administration On Aging to produce a comprehensive manual on the preparation of familiar foods for Black culture. This manual features cultural information about American Blacks (southern and northern) and about Caribbean Blacks. It identifies food preferences and gives specific ideas for preparing these foods according to proper nutrition standards. The manuals are made available to each AAA director and nutrition project directors.

## STATEWIDE COMMITTEE ON MINORITY PARTICIPATION

This Subcommittee of 21 individuals who represent five groups (Black, Hispanic, Asian, American Indian and White) was established to identify barriers to minority participation in aging programs. The Subcommittee recommends strategies to eliminate or reduce the effects of the barriers:

- Service providers should report their minority data in non-aggregated forms in order to enable SOFA to evaluate how effectively a particular minority population is being served.
- Fiscal management technical assistance should be offered to minority providers who, because of limited staff size, are unable to meet fiscal requirements or may experience case flow problems.
- SOFA has acted upon both recommendations; ongoing programs in predominantly Black communities receive technical assistance from the NYC Department for the Aging to improve their management capability, and SOFAs Policy Analysis Unit is currently developing a report on the Black elderly in New York State which will highlight economic, health and quality of life factors such as housing.

## NEW YORK CITY BLACK FRATERNITIES AND SORORITIES PROJECT

Ongoing meetings in New York City with representatives of the Black fraternities and sororities to provide information on the SOFA and to encourage them to design and develop projects to promote and increase the Black elderly participation in both the receipt and delivery of services.

## NATIONAL CAUCUS AND CENTER ON BLACK AGED MANAGEMENT PROGRAM

Provides on-the-job training, 35 hours per week for a year, to minority persons with backgrounds in gerontology, but who lack experience. The program objective is to place skilled minority professionals in management and policy-influencing positions at State and local levels.

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# VI. SUMMARY OF THE HEALTH SUBCOMMITTEE'S PUBLIC HEARINGS ON BLACK HEALTH CARE ISSUES

## BUFFALO AND NEW YORK CITY

# NEW YORK STATE

## GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

## SUBCOMMITTEE ON HEALTH

## NOTICE OF PUBLIC HEARING

## BLACK HEALTH CARE ISSUES IN NEW YORK STATE
## CONDITION, PROGNOSIS, PRESCRIPTION

Statewide hearings will be held to solicit public comment on the Health Subcommittee Preliminary Report on the Health Status of Blacks and the Human Services Subcommittee Preliminary Report on the AIDS crisis in the Black community.

DATES: Thursday, September 10, 1987 (Buffalo)
Thursday, October 1, 1987 (New York City)

TIME: 10:00 A.M.

PLACES: Walter J. Mahoney State Office Building
65 Court Street-Part Five Room
Buffalo, New York

Adam Clayton Powell, Jr.
Harlem State Office Building
163 West 125th Street - 3rd Floor
New York, New York

The Health Subcommittee of the Governor's Advisory Committee for Black Affairs was appointed in May 1986. Mr. Bernard Charles, Committee Chairman, appointed seventeen leading experts in the critical areas of health proposed for study. Dr. Charles Felton, Director of Medicine, Harlem Hospital and Professor Judith Jones, Associate Clinical Professor of Public Health, Center for Population and Family Health, serve as Co-Chairs of the Committee.

The Subcommittee developed a broad multidisciplinary approach to the review of the health and longevity of Blacks in New York State. The Subcommittee examined the health status of Blacks in each phase of the life cycle, maternal, infancy, childhood, adolescence, adulthood and the elderly years. Issues related to access and availability of medical care and health manpower were also addressed. Health financing, health education and State legislation were assessed as well by the Subcommittee for their direct impact on the health and longevity of Black New Yorkers.

The Subcommittee's review and analysis supported the findings of the Federal Task Force on Black and Minority Health that "lack of education and income are major factors for disease and death among Blacks." Other characteristics which significantly influence the health status of Blacks are:

- demographic profiles
- nutritional status and dietary practices
- environmental and occupational exposures
- stress and coping patterns
- access to health services

AIDS was identified by the Human Services Subcommittee as rapidly becoming the most devastating disease to impact the Black community. Excluding homicide, AIDS has become the leading cause of death in many of New York City's predominantly Black neighborhoods. The Subcommittee on Human Services chaired by Dr. James Dumpson, conducted an in-depth analysis of the social services issues, "AIDS in the Black Community: Programmatic Directions for New York State."

The purpose of this public outreach will be to solicit reaction to the recommendations included in the health Subcommittee preliminary report to the Governor and comments on the Human Services Executive Summary on AIDS.

In addition to general comments, testimony may be directed to the following:

> Will the recommendations proposed, if implemented by the State, effectively alleviate the health problems identified in the Subcommittee's Preliminary Report?
>
> Are there other major health issues that the Health Subcommittee should address in order to complete its analyses of Black health care issues?
>
> Witnesses are encouraged to prioritize and suggest additional or alternative recommendations and focus.

Oral testimony will be limited to five minutes. Witnesses are encouraged to summarize their written comments previously submitted. In preparing the order of witnesses, the Subcommittee will attempt to accommodate individual requests to speak at scheduled time. Such requests should be made on the reply form and submitted as early as possible.

Witnesses are requested to submit prepared testimony before the scheduled hearing date in order to allow sufficient time for questioning and to permit a focused discussion of the issues.

Twenty (20) copies of prepared testimony should be submitted to the Governor's Advisory Committee for Black Affairs by September 5, (for Buffalo) or September 24 (for New York City).

If you are unable to attend the hearing, the Committee would welcome written statements.

Bernard Charles
Chairman
Governor's Advisory Committee
For Black Affairs

Robert Simmelkjaer
Executive Director
Governor's Advisory Committee
For Black Affairs

Judith Jones
Co-Chair
Subcommittee on Health

Charles Pelton
Co-Chair
Subcommittee on Health

## OPENING REMARKS OF THE CHAIRMAN OF THE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS AT THE BUFFALO PUBLIC HEARING ON BLACK HEALTH CARE ISSUES

I would like to call this hearing of the Governor's Advisory Committee for Black Affairs Subcommittee on Health to order.

My name is Bernard Charles and I am the chairman of the Governor's Advisory Committee for Black Affairs. Governor Cuomo asked me in August of 1985 if I would take on the job of advising him and establishing a Committee on Black Affairs in accordance with Executive Order 66, which we have shared with you. I readily agreed, primarily because I have known the Governor for a long time, campaigned with him in his first political campaign in 1974 and have grown to respect him. When he asked if I would do this, I met with him and he assured me that I would have access to him, that he was serious about having this work done, and about soliciting a Black perspective on the service delivery system in the State. In fact, he specifically asked me not to tell him what he is doing right, but to tell him what is wrong. When the Governor met with the full Committee of thirty-three persons we believed him.

You will see listed in the reports which have been distributed to you, a group of outstanding, outspoken people who make up the Advisory Committee. At that first meeting with the Governor, he indicated that he was going to guarantee every child who graduated from high school a job. Now the Committee thought that was a wonderful thing to do, but knowing that education in our community has always been and continues to be the major way out for all of us, suggested that that was not going far enough. One of the members of the Committee said,"Governor, I would think that what you would want to guarantee is an opportunity for a college degree." The Governor said, that he liked that idea, and subsequent to that meeting, in all press releases and all conferences relating to that issue, he always referred to a job and/or guaranteed higher education opportunity. That is an example of his responsiveness to what we are trying to do. There is a lot of other evidence but I do not need to go into detail.

There were two purposes for setting up this Committee. One was clearly to issue a report based on a deliberative process. The other was to advise the Governor even while the Committee deliberated. In early 1986, a full-time executive director came on, and began to recruit a capable staff. We have been reviewing the legislation coming out of Albany, commenting on the at legislation, and making recommendations to the Governor that are particularly important to our community. Many have already been incorporated in legislation, regulations, and in the budget process.

The Health Subcommittee, established in May of 1986, has done a marvelous job. The Subcommittee decided early on that rather than submit a final report to the Governor based on the research they had done, consulting and so forth, they wanted to test the relevance of their findings and were willing to bring their report out to the community Statewide to get feedback.

I have submitted a preliminary health report to the Governor indicating that would be holding hearings in Buffalo and in New York City. When we have gleaned all of the information from these hearings we will submit a final report with recommendations to the Governor, which will include a summary of these public deliberations and our report on the status of Black health in the State of New York. So we are pleased that all of you have decided to participate in this hearing and to give us your unadulterated feedback. We want it and we welcome it.

To give you a sense of the breadth of the work of the Governor's Advisory Committee for Black Affairs, I will tell you that we have eight subcommittees. The largest is the health committee, we have a human services committee, we have an economic development and finance committee, we have a labor and employment committee, we have a Black family task force, we have a committee on immigrants of African Descent and we have a criminal justice committee. You can see that our approach to looking at the issues, and the experiences of the Black community in this State is comprehensive. One cannot look at any particular aspect of the Black experience in this State and nation without understanding the comprehensive relatedness of all these activities. So far the findings of the committees share a common theme and that is the importance of bringing the services delivered as close to the people who need it as possible.

Community-based organizations are an integral and very important part of what we are trying to accomplish. The State recognizes it, private industry recognizes it, the foundations recognize it. If you are concerned about delivering services to minority people, poor people, people who do not necessarily have access to information or limited access to services, you have to work with the community organizations that are close to these groups. Therefore, many of our recommendations address this and everything we advocate is based on that premise.

## OPENING REMARKS OF THE CHAIRMAN OF THE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS AT THE BUFFALO PUBLIC HEARING ON BLACK HEALTH CARE ISSUES

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I will be here participating and listening; That is my responsibility, however, the direction of the hearing will be in the hands of the Co-Chairpersons of the Health Subcommittee, Professor Judith Jones and Dr. Charles Felton.

# NEW YORK STATE
# GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS
# SUBCOMMITTEE ON HEALTH

## BUFFALO PUBLIC HEARING ATTENDEES
## September 10, 1987

Ms. Sylvia Carter, Medical Nurse Practitioner
Anthony Jordan Neighborhood
Health Center

Ms. Dorothy Collier, Director
Friends to the Elderly Program

Elaine Blyden
Office of the Honorable Arthur Eve
New York State Assembly

Mr. Clifton Hatchenson, Deputy Director
Geneva B. Scruggs Health Center

Ms. Louise Hopkins, Director
Kenfield-Langfield Youth in Progress

Ms. Cynthia Jefferson, Director
St. Augustine Afikan Child and Family Institute

Ms. Hazel Jeffries
Anthony L. Jordan

Ms. Shirley Kye
Black Nurses Association

Ms. Lottie Moore

Dr. Jessie Nash, Director, President
Seventy-Eight Restoration

Mr. Stanley Nnamani, Program Director
Badden Street Drug Counseling Program

Ms. Lorraine Peeler, Director of Human Resources
Seventy-Eight Restoration

Ms. Constance Sparks, Director
Jessie Nash Health Center

Mr. Earlie Waller, President
Dunkirk NAACP

Dr. Maggie Wright
State University of New York, Buffalo

## Summary of Buffalo Public Hearing on Black Health Care Issues

### September 10, 1987

### Buffalo, New York

The first of two public hearings convened by the Governor's Advisory Committee for Black Affairs Subcommittee on Health was held in Buffalo on September 10, 1987. The purpose of these hearings was to test the relevance of Subcommittee's preliminary findings in the area of health, to present the Subcommittee's report to the community at large, and to obtain feedback. The hearings were designed to solicit relevant testimony which is conveyed in this final report to the Governor. It is anticipated that the implementation of the policy and programmatic recommendations presented will improve significantly, the health status of Blacks in New York State.

### Quality, Assess and Availability of Services

Much of the testimony conveyed common concerns. Specifically, that while there seems to be a reluctance among Black people of all ages to take advantage of resources where they exist, the health report documents the significant barriers to access to health care, including the perception among many Blacks that they are not welcome based on race, cultural biases, ability to pay, etc.

In addition, there are insufficient resources for Black health care and education. Some common problems identified by a number of those who testified related to the allocation of resources, including inequity in the subsidization of programs for Blacks and lack of knowledge in the Black community relating to the availability of resources. Recommendations generated from the testimony include the following three, which specifically address quality, access and availability of services.

- Quality services must be available, accessible, and affordable in community-based facilities such as comprehensive health centers, settlement houses, and halfway houses. The church, being a strong community-based institution, should also be utilized in planning programmatic efforts as well as in the diffusion of information in the Black community.
- There is a need for stable funding of services that incorporates culturally appropriate outreach, health promotion, public relations and marketing in Black communities across the State.
- The State must identify and recruit Black community-based organizations and fund them to provide the critically needed services that the Black community so desperately needs.

The under-representation of Blacks on State planning and policy-making bodies was identified as an important area of concern. This absence of a Black perspective in planning relates directly to a number of the health problems identified by the hearing participants. For example, a number of those who offered testimony asserted that clinics and other health services are inappropriately established outside of Black communities, and are not geared toward addressing the special needs of Black people. There is a need for services that are culturally appropriate and which have outreach components targeted to the Black community.

## Cultural Issues

Several of the presenters supported the Subcommittee's recommendations which emphasized culturally appropriate services and targeted outreach nonetheless, one representative expressed concern about the language and discussion in the Health Report which categorized Blacks into various subgroups, i.e. Caribbean, African, Afro-American. It was suggested that such divisions are unnecessary because Blacks share a common history of racism and, too often, poverty; thus, they have more similarities to capitalize upon than differences.

## Adolescent Health and Mental Health

Several representatives of community based organizations supported the Subcommittee's recommendation for comprehensive adolescent health and mental health service programs. Their assessment of the needs of Black youth in relation to such programs include nutrition, exercise, stress reduction, drug education, coping skills and parenting skills. Too often, recommendations are implemented as pilot or demonstration programs. The need for permanent programs, in areas such as Buffalo, is documented by the teen pregnancy and drug abuse statistics for Black youth in that region of the State. One of every two Black children under sixteen years of age in Buffalo lives in poverty.

One youth program director raised concerns about the requirements of the children's lunch program, which only serves youngsters under twelve years of age. The age range of the children in this program is three to eighteen years. A problem arises when directors are required to withhold lunches from older children, who often haven't had enough to eat at home. As pointed out in the Health Subcommittee's Report, proper nutrition is a requirement for the healthy development of children. Consistent administrative policies are required in all State or publicity-funded nutrition and feeding programs to meet the needs of youth of all ages.

## Substance Abuse

A common concern among Buffalo and Rochester area hearing participants is substance abuse. The failure of drug rehabilitation programs is often the result of poor counseling. Drug users repeatedly leave detoxication centers with no strategy for coping with the environmental factors that contributed to their addiction. Detoxification is an insufficient intervention, particularly since it is often not community-based. Reconstruction of abandoned buildings within the community to serve as rehabilitation centers should be explored with a three-or four-month residency requirement for addicts.

continual treatment for substance abusers in a familiar setting, while making use of the condemned buildings which have become symbols of urban blight and which aid in the deterioration of Black communities.

Many health care providers have found that the Blacks seeking health services, such as drug counseling, relate better to Black service providers than to whites owing to shared historical and cultural experiences. Moreover, the Black experience in seeking medical care is typically one where a visit to a hospital or a clinic is prompted only by a severe illness or an emergency. This implies that there is a need for health providers to implement targeted outreach programs designed to encourage Blacks to seek preventive services as well as to ensure that early access to care is not prohibited by financial, racial, cultural or other socio-economic considerations.

## Training Blacks for the Health Professions

With regard to health training institutions, the need for Black representation was addressed. Specifically needed are health professionals who would be responsible for the recruitment and retention of minorities in the health professions and in health training institutions. The success of SUNY Buffalo in both recruiting and maintaining minorities in its medical school was cited as an example. The school currently has 88 minorities out of a total of 535. The importance of academic support (tutorial and enrichment programs) that would impact on retention must be emphasized.

Prior to 1986, funds to support the dissemination of information and enrichment programs were not available. It was not until the State's STEP program was instituted two years ago, that SUNY Buffalo had programs designed to assist students who were still in the process of choosing career paths. Again, there is a need for more funds to disseminate information on career programs in health and other fields. Black students need to be exposed to the health care fields in junior high school, as well as in high school. Health fairs, seminars, career days, etc., would expose them to opportunities in the field of health.

Particular concern was expressed for the training of nurses aides and homecare workers. Conflicting training requirements for these paraprofessionals, between State agencies and community-based training programs, was identified as a problem. It was recommended that the Department of Health work closer with community-based organizations in their planning and program development efforts.

## AIDS In The Black Community

According to representatives of a number of Rochester health agencies, the minority community, Black and Latino, was not consulted or considered in the preliminary report of the Rochester Task Force on AIDS, yet the number of non-white who are infected with the virus is escalating. The following were recommended to address the problem in Rochester.

- An HIV testing site should be located in Black communities in Rochester. Access to care must be

- An HIV testing site should be located in Black communities in Rochester. Access to care must be improved and easily available. Given several chemical dependency counseling centers already located in the area, an alternative confidential testing site is imperative.

- Grassroots AIDS-related education/prevention programs are desperately needed. The programs should be planned and directed by community-based organizations.

- Any education/prevention programs or services must be culturally relevant. The information directed toward Blacks should be culturally appropriate.

- As the number of minority persons with AIDS increases, the need for hospice programs becomes more urgent. These programs should be community-based with multi-cultural staff.

- The State should initiate programs that will reach persons incarcerated in prisons, jails and correctional facilities in New York State, by incorporating and integrating preventive education in their rehabilitation.

- The State should fund new rehabilitation programs within the minority community with minority professional staff to attend to the needs of detoxed clients to assist them to continue and maintain abstinence--preferably located in the Northeast and Western areas of Rochester's innercity.

- The State should contract with existing drug treatment programs in the Black community by providing financial resources and extensive training in order to expand and develop services geared toward public education and support services for substance abusers.

Representatives of a number of Black community-based social services and health organizations were concerned with the Human Services Subcommittee Report on AIDS in the Black Community. Acknowledging that the crisis had reached epidemic proportions in New York City, the number of Blacks with AIDS in upstate and Western New York is also increasing. Therefore, it was felt, that much can be learned from the New York City experience with AIDS. Preventive measures, which if implemented now, may be successful in stemming the spread of AIDS among Blacks in other New York areas.

## Representation of Upstate and Western New York on the Health Subcommittee

There was general agreement that there was insufficient representation from the Western and upstate New York areas on the Health Subcommittee. As a result, the impact of the Health Subcommittee's findings may not be as strong as it should be in upstate New York. The following recommendations were proposed to address this issues.

- There must be active, knowledgeable participation in the final report of the Subcommittee from the Black community in Western New York. Furthermore, upstate areas and Western New York should be highlighted, as New York City is, when analyzing critical health issues for Black New Yorkers. In almost every category of study the statistics for Western New York match those of New York City proportionally, particularly with regard to maternal and child health.

Several presenters agreed that a strong initial step toward the implementation of the Subcommittee's findings would be to institutionalize the Advisory Committee for Black Affairs as a permanent office in the Executive Chamber.

## OPENING REMARKS OF THE CHAIRMAN OF THE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS AT THE NEW YORK CITY PUBLIC HEARING ON BLACK HEALTH CARE ISSUES

My name is Bernard Charles and I am the Chairman of the Governor's Advisory Committee for Black Affairs. This is the second hearing of the Advisory Committee's Subcommittee on Health. Our first hearing was held in Buffalo, New York on September 10th. We are glad to see that you have come out. We have a long list of speakers for the day, clearly very distinguished members of the community, and we look forward to your comments.

The Governor's Advisory Committee was established by Executive Order 66 which orders that a Statewide committee be established to review Statewide programs in the public and private sector that affect Blacks in New York State; and to make recommendations to the Governor on ways that the State can improve upon, modify and change it's program in relationship to the particular needs of the Black community.

As you know, there are over two million Blacks in the State of New York and for the first time in the history of this State -- and I might add in the nation -- a governor has appointed a full-time staff and advisory committee to look at these issues and to advise him. The Committee has been in existence for a little over a year. We have conducted a series of studies in a variety of areas, health being one.

I would say that over this period of a year-and-a-half, the Committee has not only undertaken research, collecting data, analyzing data and preparing for a series of reports, but has also advised the Governor, as part of our responsibility, on a number of issues relating to education, health, narcotics, AIDS, employment, and economic development and we have made specific recommendations to the Governor. Many have in fact been accepted and implemented and included in the Governor's State of the State Message. The Committee is not just a committee issuing reports. It is an active, hardworking powerful committee and as issues have come up, I have turned to the Committee members and a distinguished group of about fifty people throughout the State, and asked for their advice and counsel. Our findings have been forwarded to the Governor for his action. These hearings are preliminary.

The Subcommittee on Health, will be introduced in a moment. They are a very active committee, a very powerful committee and I think one of the best committees that we have. They have worked very hard and the reception that they have received already in Buffalo, New York was encouraging. We look forward to your comments this morning.

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# NEW YORK STATE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS
## SUBCOMMITTEE ON HEALTH
## PUBLIC HEARING

## NEW YORK CITY PARTICIPANTS

## OCTOBER 1, 1987

Assemblyman William F. Boyland

Mr. Dick Campbell
Sickle Cell Foundation of Greater New York

Ms. Ravinia Cozier
New York State Department of Health

Ms. Naomi Davis
Bedford-Stuyvesant Alcoholism
Treatment Center

Ms. Sandra Davis
Minority Task Force on AIDS

Hon. David Dinkins
Manhattan Borough President

Ms. Louella Dudley (representing)
Senator Velmonette Montgomery's Office

Ms. Lorna Fairweather
Caribbean Women's Health Association

Ms. Barbara Gibson
Addiction Research and Treatment Center

Dr. Norma Goodwin
AMRON Management Consultants

Dr. John Holloman
William F. Ryan Community Health Center

Ms. Yvonne D. Jones
Greenburgh NAACP

Dr. Robert Kurtz
Metropolitan Hospital Center

Ms. Jeri Lamb
Assemblywoman Aurelia Green's Office

Mr. Donald Lawrence
Community Advisory Board
Metropolitan Hospital Center

Mr. Olvin McBarnette
Sickle Cell Center for Research, Inc.

Ms. Mari Nobles
Women in Crisis, Inc.

Ms. Sukie Ports
Minority Task Force on AIDS

Dr. Ernest Quimby
Narcotic and Drug Research, Inc.

Dr. Phyllis Harrison Ross
New York State Office of Mental Health
Minority Advisory Committee

Ms. Mary Swinger
Bedford-Stuyvesant Health Task Force

Mr. Kwardua Vanderpuye
New York City Prenatal Steering Committee

Dr. Socorro Vincente
South Brooklyn Health Center

Ms. Goldie Watkins
New York State Department of Health

# SUMMARY OF THE HEALTH SUBCOMMITTEE'S
# PUBLIC HEALTH HEARING
## OCTOBER 1, 1987
## NEW YORK CITY

The second public hearing of the Health Subcommittee was held on October 1, 1987 at the Harlem State Office Building. The purpose of this hearing was to solicit comments on the Health Subcommittee's report which examines the health status of Blacks in every phase of the life cycle and the Human Services Subcommittee's report on AIDS in the Black community. Twenty-three participants presented testimony at the New York City hearing. The following is an summary of testimony provided, including observations and recommendations offered by participants. The unedited transcript of the hearing is available upon request.

## AIDS

### Women and Aids

As of July 1987, AIDS became the leading cause of death for women between the ages of 25-34. One area in which men's and women's statistics differ significantly is in the particular vulnerability of women with high risk partners. Among New York males AIDS cases developed as the result of heterosexual activity have not been documented in significant numbers. The category, "sex partners of an at-risk group," appears to be of much greater consequence to women than to men. New York City statistics, as of August 1987, showed only 5 men in this category compared to 263 women.

There is no systematic attempt to reach those women who, even if they are aware of their partner's current or former drug use, may not be aware of the implications. It was acknowledged that while information alone may not be sufficient to change behavior, it is a critical first step. Public education campaigns to date have been heavily targeted toward women alone. This problem was identified as a continuing and contributing factor in relation to positive behavioral changes.

### Recommendations

- In addition to the dissemination of accurate information, intensive programs geared toward attitudinal and behavioral changes must be developed.
- Special housing should be developed so that mothers who have delivered babies with AIDS can be encouraged to keep their babies. This residential program should include a multidisciplinary team working with the mother assisting her with parenting and coping skills.
- Residential treatment programs must be developed specifically for the increasing population of boarder babies with AIDS.
- Residential programs should be established to provide living arrangements for entire families with AIDS.

## AIDS in the Caribbean Population

Owing to the phenomenon of undocumentation, health care services are not readily accessible to many immigrants from the Caribbean. Consequently, many immigrants do not seek health care services until their illness is at advanced stages. In addition, because AIDS was originally associated with Haitians, the stigma attached to this group has resulted in discrimination in the areas of health care, education, employment and housing.

Surveys conducted by the Caribbean Women's Health Association suggest that Caribbean immigrants face severe social, culture and medical barriers in their adjustment process. Language is one such barrier. Frustration was expressed over the lack of culturally relevant material related to AIDS education.

### Recommendation

- A multi-lingual and culturally compatible AIDS outreach and education program that would assist in the efforts to address the AIDS epidemic is needed.
- The State must support the efforts of ethnic community-based organizations to develop model outreach and educational materials and strategies that are culturally compatible for the ethnic immigrant community. Specifically, ethnic community organizations, particularly those that are health related, should receive funds and technical assistance in establishing AIDS outreach education programs. These organizations have traditionally served as an orientation base for the new immigrants and have assisted them in thier adjustments to living in the U.S.; have responded to their social, cultural, health link for them between service delivery systems; and are potentially more culturally appropriate AIDS educators.

## Intravenous Drug Use

Of the estimated 500,000 IV drug users in the United States 250,000 are in New York city. Fifty percent of New York State's IV drug users are Black, 30 percent are Hispanics. Studies of this population indicate that it is primarily a male and heterosexual. Over one-half of the IV drug using population it is estimated, already carries the infection. In New York City where there are an estimated 250,000 active intravenous drug users (IVDUs), treatment services are available for less than 40,000 of them. Unless IV drug use, directly or indirectly continues to be the primary source of the spread of AIDS to men, women and children in the Black community.

### Recommendation

- o Funding for education and health services must be made available to community-based organizations that are already working with the same population of people who are overwhelmed with many other health, economic and social problems in addition to AIDS.
- o All pregnant women who are known IV drug users or have been IVDUs, or sexual partners of IVDUs should be tested and should be encouraged to end a pregnancy if found positive.
- o Women of childbearing age should be tested for HIV infection.

### Other Aids Related Recommendations

- o Minority leadership must take a more active role in making sure that funds are available and utilized in their respective communities to address the issue of AIDS.
- o Minority media must be called upon to use their creativity to promote AIDS prevention messages in both visual and print media to educate Blacks.

- All efforts must be made to educate Black communities Statewide about the devastating effort of AIDS. Special educational programs should be developed that are culturally sensitive to the needs of specific populations.

- There is an urgent need for long-term care options and day care programs for people with AIDS (PWAs).

- Programs such as those offered by the Minority Task Force on AIDS should be made available to more people with AIDS.

- Innovative ways of approaching AIDS education have to be developed such as:

  Multi-lingual literature and media approaches especially for those which are illiterate; "Street theatre" and "old fashion door-to-door, people-to-people" communication.

- Indiscriminate testing of persons coming in contact with medical facilities should be mandated.

- Accurate nutritional information must be conveyed in as a component of AIDS education.

- There is a need for more people of color to be represented in policy-making positions such as the New York State Department of Health AIDS Institute.

- To be effective, AIDS education, risk reduction and outreach work must be placed within the context of progressive and positive empowerment which must occur within a cultural environment. This environment is defined as one in which the cause of symbols, languages, nuances, behaviors, outlooks, norms, roles and lifestyles form a part of the group's identity and way of being.

- Blacks must have access to experimental drugs. Financial support is desperately needed for the prohibitive costs of drugs and treatment. Many Black persons with AIDS or ARC cannot afford $10,000 a year for the AZT which seems to be effective in delaying the spread of the virus.

The State should encourage through financial, administrative and policy level support:

Approval of research protocols for the efficacy of traditional and nontraditional potential interventions against HIV opportunistic infections.

Coordination of government and private responses.

Training of trainers, public health officials, research and medical personnel.

Coordinated sharing of research and programmatic findings.

- The State should identify and mandate, in publicly supported programs, the most culturally appropriate forms of counseling, risk reduction and treatment.

- The State must ensure access to natural, scientific, and behavioral research into the epidemiological, physiological and social effects of AIDS, to health and social service planners, researchers, clinicians and managers.

- The State should allocate technical, financial and personnel resources to Black community-based groups and organizations.

- The State must appropriate funds, develop initiatives and opportunities for Blacks to develop medical training, clinical research careers and other scientific expertise.

- The State must provide administrative assistance, training, and financial help to caretakers of Black persons with AIDS (PWA'S). These caretakers provide emotional support and companionship; assist with shopping, laundry, meal preparation; and often negotiate on behalf of PWAs, through the social service system. Such assistance must be made available to community-based workers in order for them to provide care more effectively.

- The State must act as a catalyst in encouraging Black role models and religious institutions to accept and promote AIDS educational activities.

- The State should support, by publicizing and commiting resources to the work of those groups and individuals who have a longstanding, commendable and pioneering record in delivering treatment, prevention and support services to substance abusers and AIDS patients.

## Infant Mortality

The high rates of infant mortality in certain areas of New York State) compare awesomely with a number of third world countries. 1984 represents an all time low for infant mortality rates which have been declining steadily over the last two decades. However, examination of infant mortality rates for New York State for 1985 and 1986 reveal an increase in these rates.

The recent repeal of laws permitting pregnant teenagers confidential access to Medicaid on behalf of the unborn, and which only occasionally resulted in abortions, can be expected to contribute to an increase in neonatal mortality. One presenter reported that there have been increased delays by pregnant teens seeking to obtain health care because of this change in the Medicaid laws.

The SOBRA (Sixth Omnibus Budget Reconciliation Act) legislation provides states with the option of raising the Medicaid eligibility level above the AFDC payment levels (which in New York State is 65% of the poverty level for a family of 3 and 51% for a family of 6). Adoption of SOBRA by the New York State legislature would result in an expansion of Medicaid coverage to an additional 79,000 individuals. An increased pool of low-income pregnant women would be processed for Medicaid under a presumptive clause thereby facilitating more timely access to prenatal care and delivery, as well as follow up care. The SOBRA option would also extend coverage for infant health services through the first year of life.

As a result of increasing access to abortion services, the State has come under increased pressure by anti-abortion groups to abandon legislation proposed to expand Medicaid eligibility for teens and indigent pregnant women. The recent signing into law of the Pre-Natal Care Act of 1987, by the Governor, was cited as a major step enacting into law the pre-natal care and nutrition program and providing and additional $4 million towards increasing access to pre-natal care for approximately half of the 54,000 medically indigent women in New York State. The Act however, does not provide inpatient care which is essential for high risk populations; labor and delivery costs and maternal and new-born follow-up post-partum care are also not covered. Furthermore, the Act does not guarantee access to all potentially eligible women, nor does it guarantee care if the $23 million appropriation to cover expenses proves to be insufficient.

The Health Subcommittee's participation in generating the additional support necessary to see the passage Of SOBRA through the Senate in this new 1988 legislative session was requested.

## Recommendations

- The State must establish presumptive eligibility for prenatal care and establish universal access for infant health services.
- The State must lobby for universal coverage on the national level.
- The State must allocate additional and immediate resources to be applied toward the development of comprehensive maternal and infant care programs and the coordination of existing health, social service and educational delivery systems.
- The State must provide increased reimbursement rates for maternity care under the Pre-natal Care Act. These increased rates should be accomplished by improvements in requirements for provider

participation, including the establishment of Medicaid standards, for provision of office based maternity care incorporating risk assessment and appropriate guidelines for referral of high risk patients.

- There is a need for better coordination of services/resources and more cooperation, less competition among providers. New State initiatives must build upon the experience of others, replicating successful models where needed. Local communities need to be involved in the planning of these initiatives and programs from their inception.
- Available services must be provided in a manner that encourages women to participate. In order for outreach efforts to be effective, they must be creative, aggressive and non-traditional.

## Child Health

New strategies and techniques are required at the State level to ensure the healthy and appropriate development of children. The goal must always be to do that which is best for the individual child.

### Recommendations

- The State must provide intensive preventive services for children in New York and meet the full demand for foster care of children in need. This will necessitate a State review of policies, practices and procedures in order to address the needs of children in a way that protects them.

## Mental Health

Our understanding of violence from a health care perspective stems primarily from epidemiologic investigations of homicide. Population-based studies have repeatedly identified young, nonwhite males as being at greatest risk of victimization. Some studies have also shown a relationship between alcohol and drug-related activities and an increased risk of homicide.

- The Department of Criminal Justice should sponsor a community-based conference to enlist greater public and professional concern. The Conference would attempt to foster "community ownership" of the problem of non-fatal and fatal violence, as a public health issue.

- Various health, religious, political, and civic groups should meet to plan the conference to develop and implement follow-up approaches, and to collaborate and coordinate activities to decrease violence and homicide in the coming years. This coalition could also serve as an advisory group to the Institute and vice-versa.

It was recommended that a Violence Prevention, Training, Research and Development Institute be established in the State of New York. The purpose of this project would be to enhance the State's ability to promote a multi-faceted investigation of the impact of interpersonal violence from a health care perspective. The ultimate goal of this research would be prevention of premature death and injury and disability attributable to violence.

The Institute would:

A. Improve the quality, accessibility and range of violence prevention strategies available and accessible to victims, perpetrators, criminal justice personnel, health care providers, forensic specialists and educators.

B. Promote or affect the development of assessment and prevention methodologies/strategies and serve as a broad-based advocacy organization

C. Provide technical assistance to researchers who are engaged in or wish to be engaged in research that will affect violence prevention. These same technical supports will be made available to researchers who are engaged in or wish to conduct research projects that will produce an information base on violence prevention issues.

D. Establish an Information Research Center that would identify, produce, catalog, and disseminate data research findings and literature on issues that relate to violence prevention.

E. Provide community and public health educators and other services directed toward the primary and/or secondary prevention of violence.

F. Make violence prevention policy recommendations to the Office of the Criminal Justice Coordinator and other relevant agencies such as the Office of Mental Health, Department of Health, as well as media and educational service providers.

G. Sponsor research to develop protocols for use by ambulance personnel, emergency room staff and medical/mental health clinicians. These protocols would, ideally, assist in identifying those at highest risk to become homicide victims so that scarce resources could be efficiently targeted, and help to identify what methods and interventions are most effective in preventing further victimization.

## Home Health Care

The way to ensure quality services is through a well-trained. adequately-compensated work force.

- The State must pay close attention to the direction of the rapidly growing industry of home health care workers, addressing the related issues of quality and equity.

## Health Manpower

- A school of health sciences should be established at Harlem Hospital to improve the shortage of essential health workers and to provide tangible incentives and training for local residents. Such an institution would represent a symbol of strength and positive growth for the community.

## Sickle Cell Anemia

There is a crisis of large proportion in New York State that has serious consequences for those who suffer from sickle cell disease. The New York State Newborn Screening Program has identified 6,500 disease cases and over 40,000 trait cases under the age of 15 years since 1975. More than 50 percent of these cases are located in Brooklyn. There are insufficient community-based facilities and trained personnel to serve these victims with adequate follow-up care and counselling.

The funding of programs for sickle cell anemia in New York State particularly in the area of education, has been minimal. Although the federal government, since 1972, has been reasonably supportive of research, prevention, education screening and genetic counseling in sickle cell anemia through its eleven Comprehensive Sickle Cell Clinics nationwide, that support has almost been discontinued, except for a million dollar grant to Columbia Presbyterian Hospital about two years ago.

- The State must initiate community based programs to address the needs of sickle cell patients before they go into the hospital with a "crisis", and after they come out. A financial system of assistance for those with the disease is essential.

## Health Policy and Planning

There were many suggestions relating to the creation of an Office of Black Affairs, among them were the following:

- that the Office should serve as a locus for continued monitoring and advocacy for much-needed services in the Black community.
- that the Office should serve to keep the Black community informed of progress on issues of concern to Blacks and should provide an important feedback loop to State agencies on how effective their efforts have been.
- that the Office should request an annual report from agencies. For example, the Health Department should be required to issue an annual report on the status of Black health (similiar to the recent federal publication): the Department of Education and the State University of New York should be required to issue an annual report on the status of Black enrollment in educational programs; and the Department of Social Services should issue a report on the status of Blacks in the programs for which they are responsible.

Because the health concerns of Black New Yorkers necessitate an advocate with direct access to the Executive Office, it was suggested that the exact nature and responsibilities of such an office, particularly its relationship to local community efforts would need further exploration. It was also suggested that the Subcommittee recommend the creation of community health planning organizations that would have adequate resources and a formal role in the State's decision-making process.

The particular health concerns of such an Office should include:

- Acceptance of the proposal of the Health Subcommittee's recommendation on Medicaid reimbursement to the provider and expansion of eligibility for the consumer and the extension of insurance coverage at nominal fees for the Medicaid-ineligible.
- Establishment of a competent and equitable plan for certification of qualified foreign trained health professionals.
- Supportive efforts to encourage the training of community based health organization personnel to identify and mend the communications breakdown between government and the Black community so that the services available to the residents will be utilized.
- Support for community-based comprehensive health care centers, with expansion of services, where justified; creation, removal and/or substitution of services according to their relevance to community-specific needs.